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

MLN GUIDED PATHWAYS PROVIDER SPECIFIC MEDICARE RESOURCES

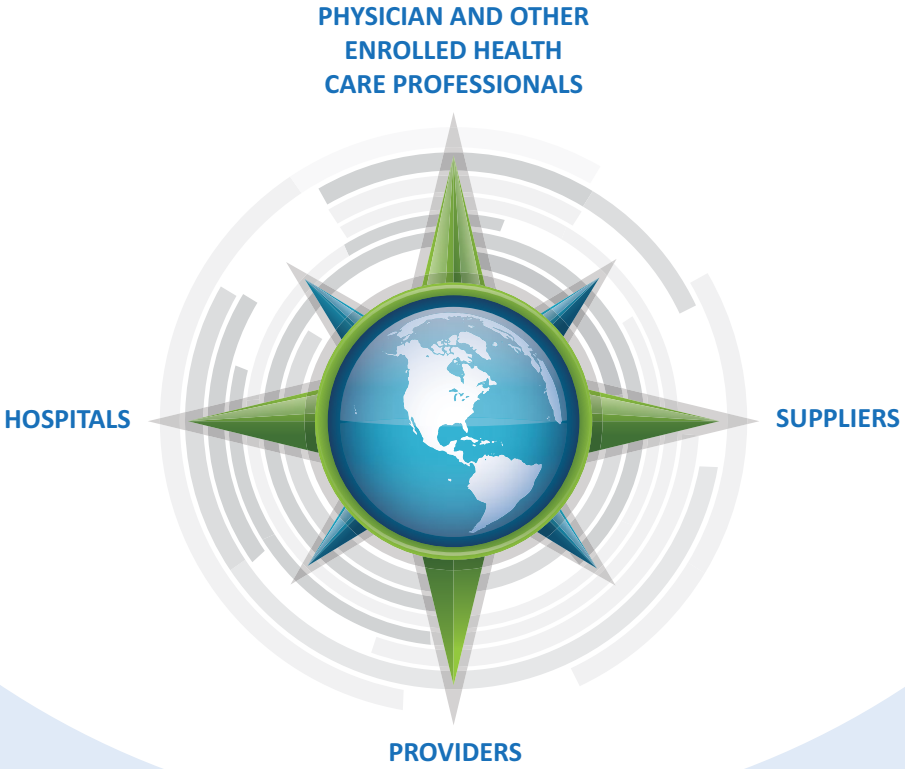

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Table of Contents

PHYSICIAN AND OTHER ENROLLED HEALTH CARE PROFESSIONALS 1

PHYSICIAN 15

DOCTOR OF MEDICINE OR OSTEOPATHY 18

ANESTHESIOLOGIST 19

OPHTHALMOLOGIST 23

CHIROPRACTOR 24

DENTIST AND ORAL OR MAXILLOFACIAL SURGEON 28

OPTOMETRIST 32

PODIATRIST 36

OTHER ENROLLED HEALTH CARE PROFESSIONALS 40

ADVANCED PRACTICE NURSES 41

ANESTHESIOLOGY ASSISTANT AND CERTIFIED REGISTERED NURSE ANESTHETIST 49

PHYSICIAN ASSISTANT 52

AUDIOLOGIST 58

CLINICAL SOCIAL WORKER 61

PSYCHOLOGIST: CLINICAL AND INDEPENDENTLY PRACTICING 65

OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST, AND SPEECH-LANGUAGE PATHOLOGIST 71

REGISTERED DIETITIAN OR NUTRITION PROFESSIONAL 79

SUPPLIERS 84

AMBULANCE SERVICE PROVIDER AND SUPPLIER 85

AMBULATORY SURGICAL CENTER 94

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES 101

FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC 118

INDEPENDENT DIAGNOSTIC TESTING FACILITY 128

LABORATORY 133

MAMMOGRAPHY CENTER OR FACILITY 144

MASS IMMUNIZATION ROSTER BILLER 149

PORTABLE X-RAY SUPPLIER 151

RADIATION THERAPY CENTER 156

PROVIDERS 159

COMMUNITY MENTAL HEALTH CENTER 160

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY 167

END STAGE RENAL DISEASE FACILITY 174

HOME HEALTH AGENCY 190

HOSPICE 211

OUTPATIENT PHYSICAL THERAPY, OTHER REHABILITATION, AND OUTPATIENT SPEECH PATHOLOGY FACILITY 222

SKILLED NURSING FACILITY 229

HOSPITALS 248

CRITICAL ACCESS HOSPITAL 284

INPATIENT PSYCHIATRIC FACILITY 293

INPATIENT REHABILITATION FACILITY 300

LONG TERM CARE HOSPITAL 306
RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION 311
TRANSPLANT CENTER 315

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PHYSICIAN AND OTHER ENROLLED HEALTH CARE PROFESSIONALS

INTRODUCTION

This curriculum is designed as a pathway to Physician and Other Enrolled Health Care Professionals Medicare resources. This pathway provides information specific to physicians and other health care professionals who are enrolled in Medicare.

More Resources: Refer to the specialty-specific pathways such as Audiologist, Doctor of Medicine or Osteopathy, Podiatrist, and Occupational Therapist, Physical Therapist, and Speech-Language Pathologist in Private Practice for further information.

Fact Sheet – "Guidelines for Teaching Physicians, Interns, and Residents"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243499.html
This fact sheet is designed to provide education on physician services in teaching settings. It includes information on payment for physician services in teaching settings, general documentation guidelines, evaluation and management (E/M) documentation guidelines, and exception for E/M services furnished in certain primary care centers. It also includes resources and a glossary.

ENROLLMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to certain physicians and other health care professionals opting out of the Medicare Program:

- 40: Effect of Beneficiary Agreements Not to Use Medicare Coverage
- 40.1: Private Contracts Between Beneficiaries and Physicians/Practitioners
- 40.2: General Rules of Private Contracts
- 40.3: Effective Date of the Opt-Out Provision
- 40.4: Definition of Physician/Practitioner
- 40.5: When a Physician or Practitioner Opts Out of Medicare
- 40.6: When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner
- 40.7: Definition of a Private Contract
- 40.8: Requirements of a Private Contract
- 40.9: Requirements of the Opt-Out Affidavit
- 40.10: Failure to Properly Opt-Out
- 40.11: Failure to Maintain Opt-Out
- 40.12: Actions to Take in Cases of Failure to Maintain Opt-Out
- 40.13: Physician/Practitioner Who Has Never Enrolled in Medicare
- 40.14: Nonparticipating Physicians or Practitioners Who Opt Out of Medicare
- 40.15: Excluded Physicians and Practitioners
- 40.16: Relationship Between Opt-Out and Medicare Participation Agreements
- 40.17: Participating Physicians and Practitioners
- 40.18: Physicians or Practitioners Who Choose to Opt Out of Medicare

- 40.19: Opt-Out Relationship to Noncovered Services
- 40.20: Maintaining Information on Opt-Out Physicians
- 40.21: Informing Medicare Managed Care Plans of the Identity of the Opt-Out Physicians or Practitioners
- 40.22: Informing the National Supplier Clearinghouse (NSC) of the Identity of the Opt-Out Physicians or Practitioners
- 40.23: Organizations That Furnish Physician or Practitioner Services
- 40.24: The Difference Between Advance Beneficiary Notices (ABN) and Private Contracts
- 40.25: Private Contracting Rules When Medicare is the Secondary Payer
- 40.26: Registration and Identification of Physicians or Practitioners Who Opt Out
- 40.27: System Identification
- 40.28: Emergency and Urgent Care Situations
- 40.29: Definition of Emergency and Urgent Care Situations
- 40.30: Denial of Payment to Employers of Opt-Out Physicians and Practitioners
- 40.31: Denial of Payment to Beneficiaries and Others
- 40.32: Payment for Medically Necessary Services Ordered or Prescribed by an Opt-out Physician or Practitioner
- 40.33: Mandatory Claims Submission
- 40.34: Renewal of Opt-Out
- 40.35: Early Termination of Opt-Out
- 40.36: Appeals
- 40.37: Application to the Medicare Advantage Program
- 40.38: Claims Denial Notices to Opt-Out Physicians and Practitioners
- 40.39: Claims Denial Notices to Beneficiaries
- 40.40: Reporting

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections related to enrollment of physicians and other health care professionals:

- 15.1: Introduction to Provider Enrollment
- 15.1.1: Definitions
- 15.1.2: Medicare Enrollment Application (Form CMS-855)
- 15.2: Provider and Supplier Business Structures
- 15.3: National Provider Identifier (NPI)
- 15.4: Provider and Supplier Types/Services
- 15.4.4: Individual Practitioners
- 15.4.4.1: Anesthesiology Assistants
- 15.4.4.2: Audiologists
- 15.4.4.3: Certified Nurse-Midwives
- 15.4.4.4: Certified Registered Nurse Anesthetists (CRNAs)
- 15.4.4.5: Clinical Nurse Specialists
- 15.4.4.6: Clinical Psychologists
- 15.4.4.7 Clinical Social Workers
- 15.4.4.8: Nurse Practitioners
- 15.4.4.9: Occupational Therapists in Private Practice
- 15.4.4.10: Physical Therapists in Private Practice
- 15.4.4.11: Physicians
- 15.4.4.12: Physician Assistants (PAs)
- 15.4.4.13: Psychologists Practicing Independently
- 15.4.4.14: Registered Dietitians
- 15.4.4.15: Speech Language Pathologists in Private Practice

- 15.5: Sections of the Forms CMS-855A, CMS-855B, and CMS-855I
- 15.5.1: Basic Information (Section 1 of the Form CMS-855)
- 15.5.2: Identifying Information (Section 2 of the Form CMS-855)
- 15.5.2.1: Licenses and Certifications
- 15.5.2.2: Correspondence Address and Email Addresses
- 15.5.2.3: Accreditation
- 15.5.2.5: Section 2 of the Form CMS-855B
- 15.5.2.6: Section 2 of the Form CMS-855I
- 15.5.4: Practice Location Information
- 15.5.4.2: Section 4 of the Form CMS-855B
- 15.5.4.3: Section 4 of the Form CMS-855I
- 15.5.5: Owning and Managing Organizations
- 15.5.6: Owning and Managing Individuals
- 15.5.8: Billing Agencies
- 15.5.13: Contact Persons
- 15.5.15: Authorized Officials
- 15.5.15.1: Form CMS-855I Signatories
- 15.5.15.2: Form CMS-855A and Form CMS-855B Signatories
- 15.5.16: Delegated Officials
- 15.7: Application Review and Verification Activities
- 15.7.1: Receipt/Review of Application and Verification of Data
- 15.7.1.4: Requesting Missing/Clarifying Data/Documentation
- 15.7.5: Special Program Integrity Procedures
- 15.7.5.1: Special Procedures for Physicians and Non-Physician Practitioners
- 15.7.6: Special Processing Guidelines for Form CMS-855A, Form CMS-855B, Form CMS-855I and Form CMS-855R Applications
- 15.10: Changes of Information and Voluntary Terminations
- 15.10.1: Changes of Information – General Procedures
- 15.10.1.1: Changes of Information and Complete Form CMS-855 Applications
- 15.10.1.2: Incomplete or Unverifiable Changes of Information
- 15.10.3: Voluntary Terminations
- 15.11: Electronic Fund Transfers (EFT)
- 15.14.1: Non-CMS-855 Enrollment Activities
- 15.14.2: Contractor Communications
- 15.14.5: Form CMS-855B Applications Submitted by Hospitals
- 15.14.6: Participation (Par) Agreements and the Acceptance of Assignment
- 15.14.7: Opt-Out
- 15.14.8: Assignment of Part B Provider Transaction Access Numbers (PTANs)
- 15.15: Internet-based PECOS Applications
- 15.16.1: Ordering/Certifying Suppliers – Background
- 15.17: Establishing an Effective Date of Medicare Billing Privileges

Fact Sheet – "PECOS for Physician and Non-Physician Practitioners"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243414.html

Learn about Medicare enrollment application submission options; how to complete an enrollment application using PECOS; and PECOS user ID and password helpful hints.

Fact Sheet – "Safeguard Your Identity and Privacy Using PECOS"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909017.html
Learn about keeping your enrollment information up to date; protecting your enrollment information; and privacy tips.

Fact Sheet – "Medicare Enrollment Guidelines for Ordering/Referring Providers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247538.html
Learn about the three basic requirements for ordering and referring; and how to enroll in Medicare as an ordering/referring provider.

MLN Matters® Article – SE1034 Revised "Physicians and Non-Physician Practitioners (NPPs) Excluded from Deactivation in Medicare Due to Inactivity with Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1034.pdf
This Special Edition MLN Matters® article explains that physicians and other health care professionals who need to enroll in the Medicare Program for the sole purpose of ordering and referring items and services for Medicare beneficiaries are excluded from the process that would deactivate them after 12 consecutive months of non-billing.

DEFINITION: SUPPLIERS

Suppliers are entities, which, in addition to providers, physicians, and health care professionals, may provide Medicare services.

More Resources: Refer to the "MLN Guided Pathways: Provider Specific Medicare Resources" pathways such as Ambulatory Surgical Center (ASC), Portable X-Ray Supplier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for more information.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description." This section explains the services of physicians and other health care professionals are covered under Part B.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes the following sections that explain what is required for certification and recertification for hospital, home health, extended care, therapy, hospice services, and DMEPOS:

- 10: Certification and Recertification by Physicians for Hospital Services – General
- 10.1: Failure to Certify or Recertify for Hospital Services
- 10.2: Who May Sign Certification or Recertification
- 10.3: Certification for Hospital Admissions for Dental Services

- 10.4: Inpatient Hospital Services Certification and Recertification
- 10.5: Selection by Hospital of Format and Method for Obtaining Statement
- 10.6: Criteria for Continued Inpatient Hospital Stay
- 10.7: Utilization Review (UR) in Lieu of Separate Recertification Statement
- 10.8: Timing of Certifications and Recertifications
- 10.8.1: Admissions On or After January 1, 1970 for Non-PPS Hospitals
- 10.8.2: Patients Discharged During Hospital Fiscal Years Beginning On or After October 1, 1983 Under PPS
- 10.9: Inpatient Psychiatric Facility Services Certification and Recertification
- 20: Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
- 20.1: Delayed Certifications and Recertifications
- 20.2: Timing for Certification and Recertification for A Beneficiary Admitted Before Entitlement
- 30.1: Content of the Physician's Certification
- 30.2: Method and Disposition of Certifications for Home Health Services
- 30.3: Recertifications for Home Health Services
- 40: Certification and Recertification by Physicians for Extended Care Services
- 40.1: Who May Sign the Certification or Recertification for Extended Care Services
- 40.2: Certification for Extended Care Services
- 40.3: Recertifications for Extended Care Services
- 40.4: Timing of Recertifications for Extended Care Services
- 40.5: Delayed Certifications and Recertifications for Extended Care Services
- 40.6: Disposition of Certification and Recertifications for Extended Care Services
- 50: Physician's Certification and Recertification for Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 60: Certification and Recertification by Physicians for Hospice Care
- 70: DME Certification
- 80: Summary Table for Certifications/Recertifications

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," includes information on ordering/referring services as well as coverage for physicians and other health care professionals:

- 20.3: Encounter Defined
- 20.4.4: Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010
- 20.4.5: Outpatient Diagnostic Services Under Arrangements
- 20.5.2: Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections related to coverage of a physician or other health care professionals providing services in an RHC or FQHC:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services
- 110: Physician Services
- 110.1: Dental, Podiatry, Optometry, and Chiropractic Services
- 120: Services and Supplies Furnished Incident to Physician's Services
- 120.1: Provision of Incident to Services and Supplies
- 120.2: Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC

- 130.2: Physician Supervision
- 170: Mental Health Visits
- 180: Physical and Occupational Therapy
- 200: Telehealth Services
- 220: Preventive Health Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to coverage for physicians and other health care professionals under Medicare Part B:

- 10: Supplementary Medical Insurance (SMI) Provisions
- 30: Physician Services
- 30.1: Provider-Based Physician Services
- 30.2: Teaching Physician Services
- 30.3: Interns and Residents
- 30.6: Indian Health Service (IHS) Physician and Nonphysician Services
- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
Chapter 5, "Items and Services Having Special DME Review Considerations," includes the following sections regarding orders from a physician or NPP to dispense DMEPOS to a beneficiary, as well as guidelines for Certificates of Medical Necessity and DME Information Forms:

- 5.2.1: Physician Orders
- 5.2.2: Verbal and Preliminary Written Orders
- 5.2.3: Detailed Written Orders
- 5.2.4: Written Orders Prior to Delivery
- 5.2.5: Face to Face Encounter Requirements
- 5.2.6: Date and Timing Requirements
- 5.2.7: Requirements of New Orders
- 5.2.8: Refills of DMEPOS Items Provided on a Recurring Basis
- 5.3: Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs)
- 5.3.1: Completing a CMN or DIF
- 5.3.2: Cover Letters for CMNs

MLN Matters® Article – SE1219 "A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1219.pdf
This Special Edition MLN Matters® article is intended for physicians who refer patients to home health, order home health services, and/or certify patients' eligibility for the Medicare home health benefit, home health agencies, and NPPs.

MLN Matters® Article – SE1305 Revised "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
This Special Edition MLN Matters® article explains that under Phase 1, Medicare alerted the billing physician or other

enrolled health care provider that the identification of the ordering/referring physician or other enrolled health care provider is missing, incomplete, or invalid, or that the ordering/referring physician or other enrolled health care provider is not eligible to order or refer. Under Phase 2, Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that physician or other enrolled health care provider is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to incident to billing under Medicare Part B:

- 60: Services and Supplies
- 60.1: Incident To Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 60.3: Incident To Physician's Services in Clinic
- 60.4: Services Incident to a Physician's Service to Homebound Patients Under General Physician Supervision

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 30.3.1, "Mandatory Assignment on Carrier Claims," which explains assignment is mandated for physician services to individuals dually entitled to Medicare and Medicaid.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to billing and coding claims:

- 10: General
- 30: Correct Coding Policy
- 30.6.1: Selection of Level of Evaluation and Management Service
- 30.6.1.1: Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
- 30.6.2: Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service
- 30.6.3: Payment for Immunosuppressive Therapy Management
- 30.6.4: Evaluation and Management (E/M) Services Furnished Incident to Physician's Service by Nonphysician Practitioners
- 30.6.5: Physicians in Group Practice
- 30.6.6: Payment for Evaluation and Management Services Provided During Global Period of Surgery
- 30.6.7: Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201-99215)
- 30.6.8: Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)
- 30.6.9: Payment for Inpatient Hospital Visits – General
- 30.6.9.1: Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)
- 30.6.9.2: Subsequent Hospital Visit and Hospital Discharge Day Management Services (Codes 99231-99239)
- 30.6.10: Consultation Services
- 30.6.11: Emergency Department Visits (Codes 99281-99288)
- 30.6.12: Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292)
- 30.6.13: Nursing Facility Services

- 30.6.14: Home Care and Domiciliary Care Visits (Codes 99324-99350)
- 30.6.14.1: Home Services (Codes 99341-99350)
- 30.6.15.1: Prolonged Services With Direct Face-to-Face Patient Contact Service (ZZZ codes)
- 30.6.15.2: Prolonged Services Without Direct Face-to-Face Patient Contact Service (Codes 99358-99359)
- 30.6.15.3: Physician Standby Service (Code 99360)
- 30.6.16: Case Management Services (Codes 99362 and 99371-99373)
- 90.1: Physicians in Federal Hospitals
- 90.2: Physician Billing for End-Stage Renal Disease Services
- 90.2.1: Inpatient Hospital Visits With Dialysis Patients
- 90.3: Physicians' Services Performed in Ambulatory Surgical Centers (ASC)
- 90.4: Billing and Payment in Health Professional Shortage Areas (HPSAs)
- 90.4.3: Claims Coding Requirements
- 90.5: Billing and Payment in a Physician Scarcity Area
- 90.5.3: Claims Coding Requirements
- 90.7: Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window
- 90.7.1: Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)
- 180: Care Plan Oversight Services
- 180.1: Care Plan Oversight Billing Requirements
- 190.3: List of Medicare Telehealth Services
- 190.3.1: Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits
- 190.3.2: Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined
- 190.3.3: Follow-Up Inpatient Telehealth Consultations Defined
- 190.6.1: Submission of Telehealth Claims for Distant Site Practitioners
- 190.6.2: Exception for Store and Forward (Noninteractive) Telehealth
- 190.7: Contractor Editing of Telehealth Claims

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MLN Matters® Article – SE1036 "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities for Physicians"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1036.pdf

This Special Edition MLN Matters® article educates physicians about two vulnerabilities identified by the RAC Demonstration concerning services with excessive units billed and duplicate claims submitted to Medicare.

MLN Matters® Article – SE1104 Revised "The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1104.pdf

This Special Edition MLN Matters® article explains that incorrectly coding the place of service code on claims could result in overpayments that will need to be recovered.

MLN Matters® Article – SE1313 "Place of Service Coding for Physician Services in an Outpatient Setting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1313.pdf

This Special Edition MLN Matters® article informs providers that Recovery Auditors have identified that some physicians were incorrectly reporting place of service (POS) as office (11) when the services were provided in an

outpatient hospital (22) setting, resulting in incorrect reimbursement.

MLN Matters® Article – MM7631 Revised "Revised and Clarified Place of Service (POS) Coding Instructions"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7631.pdf

This MLN Matters® article revises and clarifies national policy for POS code assignment. It also provides instructions for the interpretation of the Professional Component (PC) and the Technical Component (TC) of diagnostic tests.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," includes Section 10.1.1, "Payment Jurisdiction Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services." The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) is governed by the payment locality where the service is furnished and will be based on the ZIP code.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections explaining payment:

- 10: General
- 20: Medicare Physicians Fee Schedule (MPFS)
- 20.1: Method for Computing Fee Schedule Amount
- 20.2: Relative Value Units (RVUs)
- 20.3: Bundled Services/Supplies
- 20.4: Summary of Adjustments to Fee Schedule Computations
- 20.4.1: Participating Versus Nonparticipating Differential
- 20.4.2: Site of Service Payment Differential
- 20.4.3: Assistant at Surgery Services
- 20.4.4: Supplies
- 20.4.5: Allowable Adjustments
- 20.4.6: Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")
- 20.5: No Adjustments in Fee Schedule Amounts
- 20.6: Update Factor for Fee Schedule Services
- 20.7: Comparability of Payment Provision of Delegation of Authority by CMS to Railroad Retirement Board
- 20.8: Payment for Teleradiology Physician Services Purchased by Indian Health Services (IHS) Providers and Physicians
- 80: Services of Physicians Furnished in Providers or to Patients of Providers
- 80.1: Coverage of Physicians' Services Provided in Comprehensive Outpatient Rehabilitation Facility
- 80.3: Unusual Travel (CPT Code 99082)
- 90.3: Physicians' Services Performed in Ambulatory Surgical Centers (ASC)
- 90.4: Billing and Payment in Health Professional Shortage Areas (HPSAs)
- 90.4.1: Provider Education
- 90.4.1.1: A/B MAC (B) Web Pages
- 90.4.2: HPSA Designations
- 90.4.4: Payment
- 90.4.5: Services Eligible for HPSA and Physician Scarcity Bonus Payments
- 90.4.6: Remittance Messages

- 90.4.7: Post-payment Review
- 90.4.9: HPSA Incentive Payments for Physician Services Rendered in a Critical Access Hospital (CAH)
- 90.4.11: Health Professional Shortage Areas (HPSA) Surgical Incentive Payment Program (HSIP) for Surgical Services Rendered in HPSAs
- 90.4.11.1: Overview of the HSIP
- 90.4.11.2: HPSA Identification
- 90.4.11.3: Coordination with Other Payments
- 90.4.11.5: Claims Processing and Payment
- 90.5.4: Payment
- 90.6: Indian Health Services (IHS) Provider Payment to Non-IHS Physicians for Teleradiology Interpretations
- 90.7: Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window
- 90.7.1: Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)
- 100.1: Payment for Physician Services in Teaching Settings Under the MPFS:
- 100.2: Interns and Residents
- 190.1: Background
- 190.3.1: Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits
- 190.4: Conditions of Payment
- 190.5: Originating Site Facility Fee Payment Methodology
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site
- 190.7: A/B MAC (B) Editing of Telehealth Claims
- 210: Outpatient Mental Health Treatment Limitation
- 210.1: Application of the Limitation
- 230: Primary Care Incentive Payment Program (PCIP)
- 230.1: Definition of Primary Care Practitioners and Primary Care Services
- 230.2: Coordination with Other Payments
- 230.3: Claims Processing and Payment

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IOM – "Medicare Quality Reporting Incentives Programs Manual," Pub. 100-22, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qri122c01.pdf
Chapter 1, "The Physician Quality Reporting System," explains the voluntary reporting program that provides an incentive payment to identified individual Eligible Professionals (EPs) and group practices who satisfactorily report data on quality measures for covered professional services furnished by EPs during a specified reporting period.

IOM – "Medicare Quality Reporting Incentives Programs Manual," Pub. 100-22, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qri122c02.pdf
Chapter 2, "The Electronic Prescribing (eRx) Incentive Program," focuses on the requirements for eRx, a quality reporting incentive program which promotes the adoption and use of eRx systems.

IOM – "Medicare Quality Reporting Incentives Programs Manual," Pub. 100-22, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qri122c03.pdf
Chapter 3, "Contractor Incentive Program Payment Operational Instructions," describes the yearly payment instructions used by Medicare Contractors when making incentive payments described in this manual.

Webpage – Physician Quality Reporting System

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
This webpage provides information on the Physician Quality Reporting System (PQRS), including an incentive payment for EPs who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries.

Webpage – Physician Quality Reporting System – Help Desk Support

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/HelpDeskSupport.html
This webpage includes two Physician Quality Reporting System Help Desk Resources that are available for eligible professionals, including the Provider Call Center Toll–Free Numbers Directory and the QualityNet Help Desk.

Webpage – Electronic Prescribing (eRx) Incentive Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html
This webpage provides information on the Electronic Prescribing Incentive Program. 2013 was the final program year for participating and reporting in the program. Reference materials associated with the ERx incentive payment, payment adjustment, and feed back reports will remain available on this website.

Webpage – E-Prescribing

https://www.cms.gov/Medicare/E-Health/Eprescribing/index.html
This webpage provides an overview of electronic prescribing, which is a prescriber's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.

Webpage – Physician Fee Schedule Search Tool

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx
This MPFS lookup tool can be used to determine the number of post-operative days included in a procedure, whether a code is paid by Medicare, the level of supervision required for each service entered, whether modifiers can be submitted on a code, and the amount paid to the physician in a facility or in the physician's office. To use the tool, go the the Physician Fee Schedule Start Search button in the middle of the page.

Webpage – Physician Fee Schedule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html
The information that is provided on the MPFS webpage relates to payment under the MPFS and information concerning the development of the payment amounts.

Booklet – "How to Use the Searchable Medicare Physician Fee Schedule"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254368.html
Learn about navigating the Medicare Physician Fee Schedule; searching for payment information, pricing, Relative Value Units; and payment policies.

Fact Sheet – "Medicare Physician Fee Schedule"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243670.html
This fact sheet is designed to provide education on the Medicare Physician Fee Schedule (PFS). It includes the following information: physician services, Medicaer PFS payment rates, and resources.

Document – "2014 Physician Quality Reporting System (PQRS): Claims Reporting Made Simple"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014PQRS_SatisfRprtng-Claims_F11-26-2013.pdf
This document describes claims-based reporting and outlines steps that EPs or practices should take prior to participating. It also provides helpful reporting tips for EPs and their billing staff.

Document – "2015 Physician Quality Reporting System (PQRS) Claims-Based Coding and Reporting Principles"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015PQRS_Claims_CodingRpgPrinc.pdf
This document describes claims-based coding and reporting, and outlines steps that eligible professionals (EPs) should take prior to participating in 2015 PQRS.

Webpage – Electronic Health Records (EHR) Incentive Programs

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms
This webpage explains how the Medicare EHR Incentive Program will provide incentive payments to eligible professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Document – "2015 Physician Quality Reporting System (PQRS): Electronic Health Record (EHR) Reporting Made Simple"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015PQRS_EHR_Made_Simple.pdf
This document outlines electronic reporting using an EHR for 2015 PQRS and applies to:

- Individual EPs who wish to report electronically using an EHR
- PQRS group practices that registered for electronic reporting using an EHR via the GPRO
- Although this document briefly mentions the requirements for avoiding the 2017 PQRS payment adjustment, complete information is available on the CMS PQRS website

Document – "Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) 2015 Criteria Document"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_GPRO_Criteria.pdf
This document applies to group practices interested in taking part in 2015 PQRS through the GPRO via a qualified registry, Certified Electronic Health Record Technology (CEHRT), or the GPRO Web Interface reporting mechanism.

Fact Sheet – "2014 Physician Quality Reporting System (PQRS): Maintenance of Certification Program Incentive Made Simple"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014_MOCP_IncentiveMadeSimple_Final11-15-2013.pdf
This fact sheet provides steps for successful participation in the Maintenance of Certification Program Incentive. It also explains the role of the qualified Maintenance of Certification Program Incentive entity.

QUALITY

Webpage – National Practitioner Data Bank

https://www.npdb.hrsa.gov
This webpage contains information about the Data Bank, which was set up to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges.

Webpage – Medicare FFS Physician Feedback Program/Value-Based Payment Modifier

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
This webpage outlines how the Physician Feedback/Value-Based Modifier Program provides comparative performance information to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care. The tabs on the left of the page contain additional information.

Webpage – Shared Savings Program

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
This webpage explains the shared savings program which was designed to improve beneficiary outcomes and increase value of care by promoting accountability for the care of Medicare FFS beneficiaries, requiring coordinated care for all services provided under Medicare FFS, and encouraging investment in infrastructure and redesigned care processes.

Fact Sheet – "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN-907405.html
This fact sheet is designed to provide education on the methodology for determining shared savings and losses under the Medicare Shared Savings Program. It includes an overview of the program, a description of the two tracks providers can choose, and a description of how Medicare determines the shared savings or loss.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Podcast – "Information on the National Physician Payment Transparency Program: Open Payments"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908961-Podcast.html
This podcast is designed to provide education on Section 6002 of the Affordable Care Act. It includes information on increasing public awareness of financial relationships among manufacturers, providers and organizations who participate in the Medicare Program.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term non-physician for related questions and answers. For example, FAQ3619 addresses which Medicare specialty designations may potentially qualify as primary care physicians or NPPs.

Webpage – Open Door Forums – Physicians, Nurses and Allied Health Professionals Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_PNAHP.html
The Physicians, Nurses, and Allied Health Professionals Open Door Forum addresses the concerns and issues of Medicare and Medicaid physicians, non-physician practitioners, nurses, and other allied health care specialists. This diverse group of providers serves Medicare and Medicaid beneficiaries in almost all service settings, ranging from independent physician offices to specialized departments within larger facilities. The types of issues that come up during this forum are as varied as the providers who participate, but some frequent topics include the MPFS, Stark regulations, care plan oversight, payment and documentation rules, Internet-based PECOS, as well as the roles and responsibilities of different allied health professional staff under CMS regulations. Timely announcements and clarifications regarding important rulemaking, quality program initiatives, and other related areas are also included in the forums.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) issues reports on physician and health care professional services. Use the search feature on the home page of this website to review these. The OIG also has a "Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse."

Electronic Mailing Lists – Physicians

https://list.nih.gov/searchlsv.html
There are a number of physician-related electronic mailing lists administered by CMS. From the Search page select 'List Name' from the drop-down box and then enter 'physician' in the search field.

More Resources: Refer to the Medicare Learning Network® fact sheet titled "Medical Privacy of Protected Health Information" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243325.html for further information regarding the Health Insurance Portability and Accountability Act (HIPAA) and medical privacy.

MLN Matters® Article – SE1250 "Prescription Drug Monitoring Programs: A Resource to Help Address Prescription Drug Abuse and Diversion"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1250.pdf
This Special Edition MLN Matters® article is designed to provide education on Prescription Drug Monitoring Programs (PDMPs), which are designed to collect data on prescriptions of controlled substances in an effort to reduce prescription drug abuse and diversion. It includes background information about the program and resources physicians, pharmacists, nurses, and other health care professionals can use to help address and prevent prescription drug abuse.

PHYSICIAN

Definition: Physician

Medicare defines physician to mean:

- Doctor of medicine, doctor of osteopathy (including osteopathic practitioner);
- Doctor of dental surgery or dental medicine (within limitations);
- Doctor of podiatric medicine (within limitations); or
- Doctor of optometry (within limitations); and,
- With respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

A 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.

Definition: Intern/Resident

For Medicare purposes, the terms interns and residents include physicians participating in approved graduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting; for example, individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a fellow, it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, services of interns and residents are paid as provider services by the Medicare Administrative Contractor.

Definition: Teaching Physician

A teaching physician is a physician (other than an intern or resident) who involves residents in the care of their patients. Generally, teaching physicians must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the Medicare Physician Fee Schedule (MPFS).

More Resources: Various physician specialties listed on the Form CMS-855I have separate pathways with information of specific relevance. For example, the Ophthalmologist and Optometrist pathways provide information on eye care.

Webpage – Physician Center

https://www.cms.gov/Center/Provider-Type/Physician-Center.html

The Physician Center contains helpful links to billing/payment, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations/legislation, contacts, and educational resources for physicians.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage presents an overview of the physician self-referral law, which prohibits physicians from referring Medicare beneficiaries for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship unless an exception applies. Physician is defined as a doctor of medicine or osteopathy, a doctor of dental surgery or medicine, a doctor of podiatric medicine, a doctor of podiatry, or a chiropractor.

Electronic Mailing List – Physicians

https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L
The Physicians electronic mailing list is administered by CMS, which emails subscribers general Medicare, Prospective Payment System (PPS), and fee schedule information targeted toward the needs and interested of the physician.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections which explain whether certain physicians can order or refer services. Interns and residents are also defined.

- 70: Physician Defined
- 70.1: Doctors of Medicine and Osteopathy
- 70.2: Dentists
- 70.3: Doctors of Podiatric Medicine
- 70.5: Optometrists
- 70.6: Chiropractors
- 70.7: Interns and Residents

Webpage – Physician Bonuses

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html
This CMS webpage includes links to valuable information about Health Professional Shortage Area (HPSA) and HPSA Surgical Incentive Payment (HSIP) bonuses.

Web-Based Training – "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians"

https://learner.mlnlms.com/
This WBT course is designed to provide education on the federal laws that combat fraud and abuse. It includes the identification of ''red flags'' that could lead to potential legal liability, compliance recommendations for physicians, real-life fraud and abuse case examples, and helpful online resources about fraud and abuse.

Booklet – "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html
This booklet is designed to provide education for physicians on understanding how to comply with Federal laws that combat fraud and abuse and ensure appropriate quality medical care. It includes information on identifying "red flags" that could lead to potential liability in law enforcement and administrative actions.

Fact Sheet – "Health Professional Shortage Area (HPSA) Physician Bonus Program"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246598.html
Learn about the definition of a Health Professional Shortage Area (HPSA) and the HPSA bonus payment.

Fact Sheet – "Global Surgery"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1256840.html

This fact sheet is designed to provide education on the components of a global surgery package. It includes information about billing and payment rules for surgeries, endoscopies, and global surgical packages that are split between two or more physicians.

MLN Matters® Article – MM7747 "Application of the Multiple Procedure Payment Reduction (MPPR) on Imaging Services to Physicians in the Same Group Practice"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7747.pdf

This MLN Matters® article explains CMS is expanding the MPPR on the Professional Component (PC) and Technical Component (TC) of imaging services by applying it to physicians in the same group practice (same Group National Provider Identifier [NPI]) who furnish multiple services to the same beneficiary, in the same session, on the same day.

MLN Matters® Article – MM7848 "Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf

This MLN Matters® article explains CMS is expanding the MPPR policy by applying MPPRs to the TC of diagnostic cardiovascular and ophthalmology procedures. The MPPRs on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day.

DOCTOR OF MEDICINE OR OSTEOPATHIC MEDICINE

INTRODUCTION

This curriculum is designed as a pathway to Doctor of Medicine or Osteopathic Medicine Medicare resources.

Definition: Doctor of Medicine or Osteopathy

The Medicare requirement that a Doctor of Medicine (MD) be legally authorized to practice medicine and surgery by the State in which the doctor performs services means a physician is licensed to practice medicine and surgery. A Doctor of Osteopathic Medicine (DO) who is legally authorized to practice medicine and surgery by the State in which the doctor performs a service qualifies as an osteopath. In addition, a licensed osteopath or osteopathic practitioner qualifies as a physician to the extent the physician performs services within the scope of the physician's practice as defined by State law.

More Resources: Medicare provides coverage for a Doctor of Medicine or Osteopathic Medicine to perform certain Medicare services that other types of physicians are not, such as serve as an attending physician for the purpose of administering hospice benefits or perform a screening colonoscopy. Refer to the Hospice, Hospital, and other pathways for further information.

ANESTHESIOLOGIST

INTRODUCTION

This curriculum is designed as a pathway to Anesthesiologist Medicare resources.

DEFINITION: ANESTHESIOLOGIST

An anesthesiologist is a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) trained to provide pain relief and maintenance, or restoration, of a stable condition during and immediately following an operation or an obstetric, therapeutic, or diagnostic procedure. The anesthesiologist assesses the risk of the beneficiary undergoing surgery and optimizes the beneficiary's condition prior to, during and after surgery. In addition to these management responsibilities, the anesthesiologist provides medical management and consultation in pain management and critical care medicine. Anesthesiologists diagnose and treat acute, long-standing and cancer pain problems; diagnose and treat patients with critical illnesses or severe injuries; direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation; and supervise post-anesthesia recovery.

Webpage – Anesthesiologists Center

https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html
The Anesthesiologists Center contains helpful links to billing/payment, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, participation, contacts, and educational resources for physicians and other enrolled health care professionals who provide anesthesiology services.

More Resources: Refer to the "MLN Guided Pathways: Provider Specific Medicare Resources" Anesthesiology Assistant (AA) and Certified Registered Nurse Anesthetist (CRNA) pathway for additional information on providing anesthesia services to Medicare beneficiaries.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

ANESTHESIA: HOSPITALS

The provision of anesthesia services is an optional hospital service. However, if a hospital provides any degree of anesthesia service to its beneficiaries, the hospital must comply with all the requirements of this Condition of Participation (CoP). Refer to the Hospital pathway for additional information on providing anesthesia in a hospital setting.

IOM – "State Operations Manual," Pub. 100-07, Appendix A

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," provides guidance to surveyors reviewing compliance with Conditions of Participation for anesthesia services when furnished by a hospital.

ANESTHESIA: AMBULATORY SURGICAL CENTERS

Refer to the Ambulatory Surgical Center (ASC) pathway for additional information on providing anesthesia in an ASC.

COVERAGE

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes reference to an anesthesiologist or anesthesia in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 10.1: Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery
- 10.2: Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain
- 10.6: Anesthesia in Cardiac Pacemaker Surgery

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information," which explains that for anesthesia the elapsed time (in total minutes) should be shown in item 24g. Instructions for item 32 indicate for services payable under the physician fee schedule and anesthesia services, enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. In item 32, also enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home, –12.

CLAIMS PROCESSING AND PAYMENT

Anesthesia: Physicians

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," includes Section 10.1.1, "Payment Jurisdiction Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services." This section explains that the jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. When a physician, practitioner, or supplier furnishes anesthesia services in payment localities that span more than one Medicare Administrative Contractor's (MACs) service area (for example, a provider has separate offices in multiple localities and/or multiple MACs), separate claims must be submitted to the appropriate area MACs for processing.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to services performed by an anesthesiologist include:

Chapter I General Correct Coding Policies
Chapter II Anesthesia Services (CPT codes 00000-09999)

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Anesthesia: Hospitals

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 40.3, "Outpatient Services Treated as Inpatient Services." This section states diagnostic services provided to a beneficiary by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or Current Procedural Terminology (CPT) codes related to anesthesia services:

- 0371: Anesthesia incident to radiology
- 0372: Anesthesia incident to other diagnostic services

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," of this manual outlines modifiers for anesthesia services in the following sections:

- 20.6.4: Use of Modifiers for Discontinued Services
- 250.3.2: Physician Rendering Anesthesia in a Hospital Outpatient Setting

Anesthesia: Ambulatory Surgical Centers

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 90.3, "Physicians' Services Performed in Ambulatory Surgical Centers (ASC)," with specifics on what is separately billable in an ASC.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term anesthesiologist for related questions and answers. For example, FAQ2687 discusses if anesthesiologists are required by law to accept Medicare assignment.

OPHTHALMOLOGIST

INTRODUCTION

This curriculum is designed as a pathway to Ophthalmologist Medicare resources.

Webpage – MLN Products – Ophthalmology Resource Information

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ophthalmology.html
This webpage is for Medicare Fee-For-Service health care professionals who provide ophthalmic services to Medicare beneficiaries. The page provides links to relevant Centers for Medicare & Medicaid Services (CMS) rulings, correct coding edits, and other important information.

DEFINITION: OPHTHALMOLOGIST

An ophthalmologist is a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) who has completed medical school and an ophthalmology residency who specialized in eye and vision care.

More Resources: Refer to the Optometrist pathway for information on enrollment, coverage, billing, and payment for both ophthalmologists and optometrists.

CHIROPRACTOR

INTRODUCTION

This curriculum is designed as a pathway to Chiropractor Medicare resources.

DEFINITION: CHIROPRACTOR

A chiropractor, as defined by Medicare, is an individual who is licensed as a chiropractor by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which the individual performs such services), and who meets uniform minimum standards with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which the chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided. A licensed chiropractor who meets uniform minimum standards is a physician for specified services.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 70.6, "Chiropractors." This section outlines the definition of a chiropractor, licensure and authorization to practice, and minimum standards.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 40.4, "Definition of Physician/Practitioner." This section explains that the opt out law does not define physician to include a chiropractor; therefore, a chiropractor may not opt out of Medicare and provide services under private contract.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.4.11, "Physicians." This section explains that a physician must be legally authorized to practice medicine by the State in which he/she performs such services in order to enroll in the Medicare Program and to retain Medicare billing privileges. A chiropractor who meets Medicare qualifications may enroll in the Medicare Program.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining coverage for a chiropractor's services:

- 30.5: Chiropractor's Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 240: Chiropractic Services – General

- 240.1.1: Manual Manipulation
- 240.1.2: Subluxation May Be Demonstrated by X-Ray or Physician's Exam
- 240.1.3: Necessity for Treatment
- 240.1.4: Location of Subluxation
- 240.1.5: Treatment Parameters

MLN Matters® Article – SE1101 Revised "Overview of Medicare Policy Regarding Chiropractic Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1101.pdf
This Special Edition MLN Matters® article highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

MLN Matters® Article – SE1305 Revised "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
This Special Edition MLN Matters® article explains chiropractors are not eligible to order or refer supplies or services.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections which apply to billing for a chiropractor's services:

- 30.3.12: Carrier Annual Participation Program
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.1.2: Annual Medicare Physician Fee Schedule File Information
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 220, "Chiropractic Services." This section explains the documentation requirements when billing for a chiropractor's services.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section includes specific instructions for chiropractic services for items 14, 17, and 19.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI, "Medicine, Evaluation and Management Services (CPT Codes 90000-99999)," includes information on chiropractic manipulative treatment.

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CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 240, "Chiropractic Services – General." This section establishes that payment for chiropractic services is based on the Medicare Physician Fee Schedule (MPFS) and that payment is made to the beneficiary or, on assignment, to the chiropractor.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 220, "Chiropractic Services," which explains the claims processing edits related to payment for a chiropractor's services.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes Section 30, "Services Paid Under the Medicare Physician's Fee Schedule." This section explains that a chiropractor is paid under the MPFS.

BENEFICIARY NOTICES

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes reference to Advance Beneficiary Notices (ABNs) in Section 240.1.3, "Necessity for Treatment."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes Section 20.9.1.1, "Instructions for Codes With Modifiers (A/B MACs (B) Only)." This section outlines the modifiers that may be used when a chiropractor notifies a beneficiary the item or service may not be covered.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes detailed instructions on completing the ABN and use of the GA modifier.

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QUALITY

Website – eGlobalTech (eGT)

http://www.cbrinfo.net
This website provides the most recent Comparative Billing Reports (CBR) with links to past and upcoming webinars, teleconferences and samples for that specific CBR. A CBR is a documented analysis that shows a provider's billing pattern for various procedures or services and compares that billing to their peers. Sample reports are available for podiatry, electrodiagnostic studies, ambulance, diabetic testing supplies, nebulizer drugs, orthoses, and positive airway pressure (PAP).

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about chiropractic services. Use the search feature on the home page of this website to review these.

DENTIST AND ORAL OR MAXILLOFACIAL SURGEON

INTRODUCTION

This curriculum is designed as a pathway to Dentist and Oral or Maxillofacial Surgeon Medicare resources.

DEFINITION: DENTIST

A dentist as defined by Medicare qualifies as a physician if the dentist is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which the dentist performs such function and who is acting within the scope of the dentist's license when such functions are performed. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; for example, dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections, and interpretations of diagnostic X-ray examinations in connection with covered services.

DEFINITION: ORAL OR MAXILLOFACIAL SURGEON

An oral or maxillofacial surgeon specializes in the area of dentistry which includes the diagnosis and treatment of disease, injuries, and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. An oral or maxillofacial surgeon must be licensed in the State in which services are performed.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections regarding enrollment for a doctor of dental medicine or a doctor of dental surgery:

- 15.4.4.11: Physicians
- 15.16.1: Ordering/Certifying Suppliers – Background

Fact Sheet – "Medicare Enrollment Guidelines for Ordering/Referring Providers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247538.html
Learn about the three basic requirements for ordering and referring; and how to enroll in Medicare as an ordering/referring provider.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which explains that prosthetic and orthotic dental devices are not covered under Part B.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf

Chapter 4, "Physician Certification and Recertification of Services," includes Section 10.3, "Certification for Hospital Admissions for Dental Services." This section explains the authority of the attending doctor of dental surgery or of dental medicine regarding hospitalization.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 70.2, "Dentists." This section outlines coverage for dental services under Medicare.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 70, "Inpatient Services in Connection With Dental Services." This section explains coverage for hospital inpatient services and the dentist's services when a beneficiary is hospitalized for a dental procedure.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining coverage of dental services:

- 40.4: Definition of Physician/Practitioner
- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 120: Prosthetic Devices
- 150: Dental Services
- 150.1: Treatment of Temporomandibular Joint (TMJ) Syndrome

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions from Coverage," includes Section 140, "Dental Services Exclusion." This section outlines which dental services may or may not be covered under the Medicare Program.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to dental services in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 260.6: Dental Examination Prior to Kidney Transplantation

BILLING OTHER RESOURCES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section includes information about where to include the name of the referring or ordering doctor of dental surgery or dental medicine on Form CMS-1500 or its electronic equivalent. It also explains when dental examinations are billed, the specific surgery for which the exam is being performed should be entered on Form CMS-1500 or its electronic equivalent.

Fact Sheet – "Medicaid Compliance and Your Dental Practice"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908668.html
This fact sheet is designed to provide education on internal compliance programs for dental practices that submit Medicaid claims. It includes information on the value and core elements of a compliance program, steps to establish a compliance program, and other resources.

Webpage – Code Sets Overview

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html
This webpage provides a link to the American Dental Association (ADA), which maintains and distributes the Code on Dental Procedures and Nomenclature (CDT) (the code set for dental services).

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 150, "Dental Services." This section explains payment for covered dental procedures, services, and supplies.

MLN Matters® Article – MM7035 – "American Recovery and Reinvestment Act of 2009 Electronic Health Record (EHR) Incentive Program: Healthcare Common Procedure Coding System (HCPCS) Modifier for the EHR Incentive Program"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7035.pdf
This MLN Matters® article explains the EHR Health Professional Shortage Area (HPSA) modifier which allows EHR Eligible Professionals (EPs) to report claims rendered in a dental HPSA when the ZIP code does not fully fall within that dental HPSA. A Doctor of Dental Medicine or Doctor of Oral Surgery are two of many EPs eligible to participate.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections regarding the use of an Advance Beneficiary Notice of Noncoverage (ABN) for dental care:

- 20.2.1: Categorical Denials
- 50.3.2: Voluntary ABN Uses

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term cataracts for related questions and answers. For example, FAQ8213 addresses which ordering /referring physician should be listed on the claim when an ophthalmologist performs cataract surgery and refers the patient to an Optometrist who orders glasses for the patient.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about dentists. Use the search feature on the home page of this website to review these.

Electronic Mailing List – USPHS Dentist

https://list.nih.gov/cgi-bin/wa.exe?A0=dentist-l
This electronic mailing list, created by the Dental Professional Advisory Committee (DePAC) of the United States Public Health Service (USPHS), provides a means for public health dentists to communicate outside of their own agencies, while at the same time enabling DePAC and other entities to provide immediate dissemination of important information to USPHS dentists from across the country.

Electronic Mailing List – Oral Health

https://list.nih.gov/cgi-bin/wa.exe?A0=oralhealth
This electronic mailing list emails subscribers dental coverage updates for the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) Programs.

OPTOMETRIST

INTRODUCTION

This curriculum is designed as a pathway to Optometrist Medicare resources. It also includes information that may be relevant to an Ophthalmologist.

DEFINITION: OPTOMETRIST

A Doctor of Optometry (OD) has completed 4 years of professional education at a college of optometry. Medicare policy is that a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 70.5, "Optometrists."

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections with reference to ophthalmology or optometry:

- 30.4: Optometrist's Services
- 80.6.2: Interpreting Physician Determines a Different Diagnostic Test is Appropriate
- 130: Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 280.1: Glaucoma Screening

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions From Coverage," includes Section 90, "Routine Services and Appliances," about eyeglasses, contact lenses, and eye examinations.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to the care of eyes in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 10.1: Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery
- 80.1: Hydrophilic Contact Lens for Corneal Bandage
- 80.2: Photodynamic Therapy
- 80.2.1: Ocular Photodynamic Therapy (OPT) – Effective April 3, 2013
- 80.3: Photosensitive Drugs
- 80.3.1: Verteporfin – Effective April 3, 2013
- 80.4: Hydrophilic Contact Lenses
- 80.5: Scleral Shell
- 80.6: Intraocular Photography
- 80.7: Refractive Keratoplasty
- 80.7.1: Keratoplasty
- 80.8: Endothelial Cell Photography
- 80.9: Computer Enhanced Perimetry
- 80.10: Phaco-Emulsification Procedure – Cataract Extraction
- 80.11: Vitrectomy
- 80.12: Intraocular Lenses (IOLs)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," includes Section 10.1.3, "Prosthetics and Orthotics (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) – Coverage Definition."

More Resources: Refer to the CMS Preventive Services Provider Resources webpage at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html for additional resources regarding coverage of glaucoma screenings for Medicare beneficiaries.

Fact Sheet – "Medicare Vision Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254655.html
Learn about coding requirements as well as coverage guidelines and exclusions.

MLN Matters® Article – SE1305 Revised "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
This Special Edition MLN Matters® article specifies that optometrists may only order and refer DMEPOS products or services, laboratory, and x-ray services payable under Medicare Part B.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes reference to doctor of optometry in Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section explains the name of the referring or ordering physician is entered in Item 17.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes the following sections related to billing for intraocular lenses:

- 120: Presbyopia-Correcting (P-C IOLS) and Astigmatism-Correcting Intraocular Lenses (A-C IOLs) (General Policy Information)
- 120.2: Coding and General Billing Requirements

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes reference to an Ophthalmologist/Optometrist in the following sections:

- 30.3.5: Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers
- 30.3.12: Carrier Annual Participation Program

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes reference to optometrist in the following sections:

- 20.2: Relative Value Units (RVUs)
- 90.5.4: Payment

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes the following sections related to payment and processing claims for intraocular lenses:

- 120.1: Payment for Services and Supplies
- 120.3: Provider Notification Requirements
- 120.4: Beneficiary Liability

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to services performed by an ophthalmologist or optometrist include:

Chapter VIII Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems (CPT Codes 60000 – 69999)

Chapter XI Evaluation and Management Services (CPT Codes 90000 – 99999)

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OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term cataracts for related questions and answers. For example, FAQ8213 addresses which ordering/referring physician should be listed on the claim when an ophthalmologist performs cataract surgery and refers the patient to an Optometrist who orders glasses for the patient.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about eye care services. Use the search feature on the home page of this website to review these.

Electronic Mailing Lists – Eye and Vision Care

https://list.nih.gov/cgi-bin/wa.exe?A0=nei-eye-related-pubs
The EYEONNEI@LIST.NIH.GOV electronic mailing list is the National Eye Institute's (NEI's) online news magazine. The site includes feature stories about vision research projects, interviews with scientists, descriptions of research images, and answers to eye health questions. Eye on NEI gives readers an inside look at the vision research process, from the laboratory bench to the beneficiary's bedside.

https://list.nih.gov/cgi-bin/wa.exe?A0=visionnetwork
The VISION Public Information Network for Eye Institutes and Departments of Ophthalmology and Schools and Colleges of Optometry is coordinated by the NEI of the National Institutes of Health (NIH). Member institutions appoint a Public Information Officer to work with NEI and the Network to develop an ongoing program to inform and educate the public about the benefits of public investments in vision research. This electronic mailing list is available at VISIONNETWORK@LIST.NIH.GOV.

PODIATRIST

INTRODUCTION

This curriculum is designed as a pathway to Podiatrist Medicare resources.

DEFINITION: DOCTOR OF PODIATRIC MEDICINE (DPM) OR PODIATRIST

A DPM is a physician, but only with respect to those functions a podiatrist is legally authorized to perform in the State in which the podiatrist practices. Where permissible by State law, these services include ordering laboratory tests that are reasonably related to the legal scope of podiatric practice, that are reasonable and necessary for the diagnosis or treatment of a beneficiary's condition, and are not in connection with excluded services, such as treatment of flat foot and routine foot care.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 70.3, "Doctors of Podiatric Medicine," which specifies that, for purposes of the Medicare Program, a DPM is considered a physician for any of the following purposes:

- Making the required physician certification and recertification of the medical necessity for services
- Having a beneficiary in a Home Health Agency (HHA) under the podiatrist's care, and establishing and periodically reviewing a home health plan of treatment
- Serving as a member of a Utilization Review (UR) committee, but only if at least two of the physicians on the UR committee are doctors of medicine or osteopathy. The performance of these functions must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," includes Part B coverage of custom shoes prescribed by a podiatrist or other qualified individual.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to coverage for services and supplies provided or ordered by a podiatrist:

- 40.4: Definition of Physician/Practitioner
- 60: Services and Supplies
- 60.1: Incident to Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 140: Therapeutic Shoes for Individuals with Diabetes
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 290: Foot Care

More Resources: Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) pathway for additional information regarding coverage of DMEPOS such as therapeutic shoes and prosthetic devices for Medicare beneficiaries.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to a podiatrist or foot care in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf
- 70.2: Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility
- 70.2.1: Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy)

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 250.2: Hemorheograph

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes Section 80, "Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes," which explains coverage requirements.

Fact Sheet – "Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244980.html
This fact sheet is designed to provide education on Medicare covered podiatry services. It includes a list of services that are not covered by Medicare, billing guidelines, and a list of resources.

MLN Matters® Article – SE1113 "Foot Care Coverage Guidelines"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1113.pdf
This Special Edition MLN Matters® article is for informational purposes only for providers billing Medicare for foot care services.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections related to billing for the services of a podiatrist:
- 30.3.12: Carrier Annual Participation Program
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," Section 10.4, "Items 14-33 – Provider of Service or Supplier Information," includes information specific to claims for podiatry services.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
Chapter 5, "Items and Services Having Special DME Review Considerations," includes rules concerning physician orders for DMEPOS items and documentation that should be contained in the beneficiary's medical record.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," Section 20.2, "Relative Value Units (RVUs)," addresses RVUs for limited license physicians.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," Section 30, "Services Paid Under the Medicare Physician's Fee Schedule," explains the type of fee schedule used to pay podiatrist professional services.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections explaining the provisions which protect beneficiaries and podiatrists under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay:

- 20.2.1: Categorical Denials
- 50.3.2: Voluntary ABN Uses
- 60.2: Scope of the HHCCN

QUALITY

Webpage – Physician Quality Reporting System – Measures Codes

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
A search for foot in the current year's Measure Specifications document outlines current podiatry-related Physician Quality Reporting System specifications.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov

The Office of Inspector General (OIG) has issued reports about nail debridement services. Use the search feature on the home page of this website to review these.

OTHER ENROLLED HEALTH CARE PROFESSIONALS

Definition: Other Enrolled Health Care Professional

The Form CMS-855I refers to all enrolled health care professionals other than physicians as Non-Physician Practitioners (NPPs); however, there are other times Medicare defines NPP restrictively, often in the context of specific services. For example, for the purpose of the Initial Preventive Physical Examination (IPPE), qualified NPPs include physician assistants, nurse practitioners, and clinical nurse specialists. For the purpose of the bone mass measurement benefit, qualified non-physician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives.

The term health care professionals is used in this booklet to encompass all of these individuals other than physicians, who sign a Form CMS-855I or enroll using Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

More Resources: Each of these health care professionals is included in a pathway with information of specific relevance.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 40.4, "Definition of Physician/Practitioner." This section defines the term practitioner within the extent they are legally authorized to practice by the State and otherwise meet Medicare requirements.

Webpage – MLN Products – Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/APNPA.html
This webpage provides Medicare information and resources for Advanced Practice Registered Nurses (APRNs), Anesthesiologist Assistants (AAs), and Physician Assistants (PAs). APRNs include Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs).

Booklet – "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html
This booklet is designed to provide education on Medicare services furnished by certified registered nurse anesthetists, anesthesiologist assistants, nurse practitioners, certified nurse-midwives, clinical nurse specialists, and physician assistants. It includes the required qualifications, coverage criteria, billing, and payment for these provider types.

ADVANCED PRACTICE NURSES

INTRODUCTION

This curriculum is designed as a pathway to Advanced Practice Nurses (APNs), which includes Certified Nurse-Midwife, Clinical Nurse Specialist, and Nurse Practitioner Medicare resources. Unless information is specifically listed under the Certified Nurse-Midwife, Clinical Nurse Specialist, or Nurse Practitioner headings, the content refers to all three types of APNs. Although Certified Registered Nurse Anesthetists (CRNA) may be considered ANPs, they are addressed in the Anesthesiology Assistant and Certified Registered Nurse Anesthetist pathway.

Definition: Certified Nurse-Midwife (CNM)

A CNM must meet all the following requirements:

- Must be currently licensed to practice in the State as a registered professional nurse and meet one of the following requirements:
  - Be legally authorized under State law or regulations to practice as a nurse-midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the State; or
  - If the State does not specify a program of study and clinical experience that nurse-midwives must complete in order to practice in the State, a CNM must:
    - Be currently certified as a nurse-midwife by the American College of Nurse-Midwives; or
    - Have satisfactorily completed a formal education program of at least 1 academic year that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or
    - Have successfully completed a formal education program for preparing Registered Nurses (RNs) to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, through July 16, 1982.

Definition: Certified Registered Nurse Anesthetist

A CNS must meet all the following requirements:

- Be a RN who is currently licensed to practice in the State where he or she practices and is authorized to furnish the services of a CNS in accordance with State law
- Have a master's degree in a defined clinical area of nursing from an accredited ducational institution
- Be certified as a CNS by a recognized national certifying body that has established standards for a CNS

Definition: Nurse Practitioner (NP)

A nurse practitioner is defined as a person who:

- Is a registered professional nurse authorized by the State in which services are furnished to practice as a NP in accordance with State law and meet one of the following:
  - Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003; and:
    - Is certified as a NP by a recognized national certifying body that has established standards for NPs; and
    - Has a master's degree in nursing or a Doctor of Nursing Practice (DNP) degree.
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2003, and meets the certification requirements described above; or
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2001.

More Resources: Refer to the Physician and Other Enrolled Health Care Professional pathway for additional information on providing services to Medicare beneficiaries.

Webpage – MLN Products – Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/APNPA.html
This webpage provides Medicare information and resources for Advanced Practice Registered Nurses (APRNs), Anesthesiologist Assistants (AAs), and Physician Assistants (PAs). APRNs include CRNAs, CNMs, CNSs, and NPs.

Booklet – "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html
This booklet is designed to provide education on Medicare services furnished by certified registered nurse anesthetists, anesthesiologist assistants, nurse practitioners, certified nurse-midwives, clinical nurse specialists, and physician assistants. It includes the required qualifications, coverage criteria, billing, and payment for these provider types.

ENROLLMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare enrollment guidelines for a CNM, a CNS, or a NP:

- 40.4: Definition of Physician/Practitioner
- 180: Nurse-Midwife (CNM) Services
- 200: Nurse Practitioner (NP) Services
- 210: Clinical Nurse Specialist (CNS) Services

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections which contain enrollment guidelines for a CNM, a CNS, or a NP:

- 15.1.1: Definitions
- 15.1.2: Medicare Enrollment Application (Form CMS-855)
- 15.3: National Provider Identifier (NPI)
- 15.4.4.3: Certified Nurse-Midwives
- 15.4.4.5: Clinical Nurse Specialists
- 15.4.4.8: Nurse Practitioners
- 15.8.2: Rejections
- 15.10.1: Changes of Information – General Procedures
- 15.17: Establishing an Effective Date of Medicare Billing Privileges
- 15.21.7: Surety Bonds
- 15.27.1: Deactivations and Reactivations
- 15.27.2: Revocations

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which references Part B coverage of a CNM, a CNS, and a NP.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 1, "Definition of Inpatient Hospital Services." This section explains inpatient hospital services do not include services of a CNM, a CNS, or a NP.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," includes the following sections which explain CNM, CNS, or NP coverage, who may order and perform diagnostic tests, as well as explain supervision of therapeutic services:

- 20.1.2: Exception to Limitation
- 20.4.5: Outpatient Diagnostic Services Under Arrangements

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 8

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," includes the following sections which explain coverage of a CNM, a CNS, or a NP's services in a Skilled Nursing Facility (SNF):

- 10.2: Medicare SNF Coverage Guidelines Under PPS
- 40: Physician Certification and Recertification of Extended Care Services
- 40.1: Who May Sign the Certification or Recertification for Extended Care Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare coverage for a CNM, a CNS, or a NP:

- 60: Services and Supplies
- 60.1: Incident To Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.2: Psychological Tests and Neuropsychological Tests
- 80.5.4: Conditions for Coverage
- 80.6.1: Definitions
- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 180: Nurse-Midwife (CNM) Services
- 200: Nurse Practitioner (NP) Services
- 210: Clinical Nurse Specialist (CNS) Services
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 280.2.2: Coverage Criteria
- 280.4: Screening Pap Smears
- 310.2: Qualified Person

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions From Coverage," includes Section 170, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider." This section explains that non-physician services provided to a Part A inpatient or Part B inpatient of a hospital or to a Part A inpatient of a SNF which are not provided directly by the hospital/SNF or under arrangement generally are excluded from coverage under Medicare. This coverage exclusion does not apply to services by a CNM, a CNS, or a NP.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to a CNM, a CNS, or a NP in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 210.1: Prostate Cancer Screening Tests
- 210.2: Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections which outline coverage for a CNM, a CNS, or a NP providing preventive and screening services to beneficiaries:
- 30: Screening Pap Smears
- 40.2: Screening Pelvic Examinations on and After July 1, 2001
- 50.1: Definitions
- 60.2: HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
- 80: Initial Preventive Physical Examination (IPPE)

Clinical Nurse Specialist and Nurse Practitioner

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes Section 40.1, "Who May Sign the Certification or Recertification for Extended Care Services." This section explains a certification or recertification statement at a SNF must be signed by the attending physician or a physician on the staff of the SNF who has knowledge of the case or by a CNS or a NP who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician. Generally, for purposes of certification and recertification of Part A services, a physician must sign.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to coverage for a CNS or a NP's services:
- 30.6.1.1: Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

- 30.6.15.4: Power Mobility Devices (PMDs) (Code G0372)
- 100.1.7: Assistants at Surgery in Teaching Hospitals

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
Chapter 5, "Items and Services Having Special DME Review Considerations," includes the following sections explaining orders for Durable Medical Equipment (DME) by a CNS or a NP:

- 5.5: Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and CMNs
- 5.9.2: Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

Nurse Practitioner

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," includes the following sections which explain coverage for a NP as an attending physician in a hospice:

- 10: Requirements – General
- 20.1: Timing and Content of Certification
- 20.4: Election by Managed Care Enrollees
- 40: Benefit Coverage
- 40.1.1: Nursing Care
- 40.1.3: Physicians' Services
- 40.1.3.1: Attending Physician Services
- 40.1.3.2: Nurse Practitioners as Attending Physicians
- 40.2.1: Continuous Home Care (CHC)
- 40.3: Contracting With Physicians

Certified Nurse-Midwife and Nurse Practitioner

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections related to coverage of a CNM or a NP providing services in an RHC or FQHC:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services
- 120: Services and Supplies Furnished Incident to Physician's Services
- 120.1: Provision of Incident to Services and Supplies
- 120.2: Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC
- 130: Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services
- 130.1: NP, PA, and CNM Requirements
- 130.2: Physician Supervision
- 140: Services and Supplies Incident to NP, PA, and CNM Services
- 170: Mental Health Visits
- 180: Physical and Occupational Therapy
- 190.5: Treatment Plans
- 210: Hospice Services
- 210.1: Hospice Attending Practitioner

- 220: Preventive Health Services
- 220.1: Preventive Health Services in RHCs
- 220.2: Preventive Health Services in FQHCs

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections explaining billing for CNM, CNS, or NP services:

- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.3: Carrier Rules for Limiting Charge
- 80.3.2.1.2: Conditional Data Element Requirements for A/B MACs and DME MACs
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to billing for CNM, CNS, or NP services:

- 30.6.1: Selection of Level of Evaluation and Management Service
- 120.3: NP and CNS Billing to the A/B MAC (B)
- 180: Care Plan Oversight Services
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section states these APNs must accept assignment.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
Chapter 4, "Benefit Integrity," includes Section 4.20.2.1, "Civil Monetary Penalties Delegated to CMS." This section lists the authorities under which CMS' Program Integrity Group and the Office of Inspector General (OIG) may impose civil money penalties, assessments, and/or exclusions for program non-compliance in the event a CNM, a CNS, or a NP bills on a non-assigned basis.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare payment for a CNM, a CNS, or a NP:

- 180: Nurse-Midwife (CNM) Services
- 200: Nurse Practitioner (NP) Services
- 210: Clinical Nurse Specialist (CNS) Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to payment to a CNM, a CNS, or a NP:

- 30.6.1: Selection of Level of Evaluation and Management Service
- 80.2: Rural Health Clinic and Federally Qualified Health Center Services
- 100.1.7: Assistants at Surgery in Teaching Hospitals
- 120: Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services Payment Methodology
- 120.1: Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists
- 120.2: Outpatient Mental Health Treatment Limitation
- 130: Nurse-Midwife Services
- 130.1: Payment for Certified Nurse-Midwife Services
- 130.2: Global Allowances
- 190.3.4: Payment for ESRD-Related Services as a Telehealth Service
- 190.3.5: Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services
- 190.3.6: Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service
- 190.6: Payment - Physician/Practitioner at a Distant Site
- 210.1: Application of the Limitation
- 230.1: Definition of Primary Care Practitioners and Primary Care Services

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to services performed by a CNM, a CNS, or a NP include:

Chapter I	General Correct Coding Policies
Chapter XI	Medicine, Evaluation and Management Services (CPT Codes 90000-99999)

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Certified Nurse-Midwife

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 20.2.1, "Categorical Denials." This section explains Medicare payment under the limitation on liability provision cannot be made because the actual Medicare payment denial is based on a categorical exclusion. This includes physicians' services performed by a CNM when furnished to an inpatient, unless they are furnished under arrangement with the hospital.

Nurse Practitioner

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
This chapter explains nurse practitioner (NP) services paid under the physician fee schedule are not recognized as home health services included in the Prospective Payment System (PPS) rates.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term nurse for related questions and answers. For example, FAQ3349 explains that nurse practitioners and clinical nurse specialists are authorized to perform the Initial Preventive Physical Examination (IPPE).

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The OIG has issued reports about health care providers, which include a CNM, a CNS, or a NP. Use the search feature on the home page of this website to review these.

Clinical Nurse Specialist and Nurse Practitioner

Beneficiary Booklet – "Medicare & Your Mental Health Benefits"

https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf
This beneficiary booklet is the official government booklet about mental health benefits for Fee-For-Service Medicare beneficiaries. A CNS or a NP may refer beneficiaries to this resource.

ANESTHESIOLOGY ASSISTANT AND CERTIFIED REGISTERED NURSE ANESTHETIST

INTRODUCTION

This curriculum is designed as a pathway to Anesthesiology Assistant and Certified Registered Nurse Anesthetist Medicare resources.

DEFINITION: ANESTHESIOLOGY ASSISTANT (AA)

An AA is defined by Medicare as a person who:

- Works under the direction of an anesthesiologist
- Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on non-physician anesthetists
- Is a graduate of a medical school-based anesthesiologist's assistant education program that:
  - Is accredited by the Committee on Allied Health Education and Accreditation; and
  - Includes approximately 2 years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

DEFINITION: CERTIFIED REGISTERED NURSE ANESTHETIST

A CRNA is defined by Medicare as a registered nurse who:

- Is licensed as a registered professional nurse by the State in which the nurse practices
- Meets any licensure requirements the State imposes with respect to non-physician anesthetists
- Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary
- Meets the following criteria:
  - Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or
  - Is a graduate of a program described in the third bullet above and within 24 months after that graduation passed the certification examination discussed above.

Webpage – MLN Products – Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/APNPA.html
This webpage provides Medicare information and resources for Advanced Practice Registered Nurses (APRNs), AAs, and Physician Assistants (PAs). APRNs include CRNAs, Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs).

More Resources: Refer to the Anesthesiologist pathway for additional information on providing anesthesia services to Medicare beneficiaries.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description." This section explains the services of a CRNA are covered under Medicare Part B.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 40.4, "Definition of Physician/Practitioner." This section defines a practitioner to include a CRNA to the extent he/she is legally authorized to practice by the State and otherwise meet Medicare requirements.

Booklet – "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html
This booklet is designed to provide education on Medicare services furnished by certified registered nurse anesthetists, anesthesiologist assistants, nurse practitioners, certified nurse-midwives, clinical nurse specialists, and physician assistants. It includes the required qualifications, coverage criteria, billing, and payment for these provider types.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 30.3.1, "Mandatory Assignment on Carrier Claims." This section explains that AAs and CRNAs who provide services under the Medicare Program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
Chapter 6, "SNF Inpatient Part A Billing and SNF Consolidated Billing," includes Section 20.1.1, "Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement." This section explains that services of CRNAs are excluded from Part A Prospective Payment System (PPS) payment. It also outlines the requirement for consolidated billing and explains services must be billed separately by the CRNA to the Medicare Administrative Contractor (MAC).

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to billing for AA or CRNA services:

- 140: Qualified Nonphysician Anesthetist Services
- 140.3.2: Anesthesia Time and Calculation of Anesthesia Time Units
- 140.3.3: Billing Modifiers
- 140.3.4: General Billing Instructions
- 140.4.1: An Anesthesiologist and Qualified Nonphysician Anesthetist Work Together

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information," which states an AA and a CRNA can only be paid on an assigned basis. This section also explains that for anesthesia, the elapsed time (in total minutes) should be shown in item 24g. Instructions for item 32 indicate for services payable under the physician fee schedule and anesthesia services, enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. In item 32, also enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home, –12.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 80.3.2.1.3, "A/B MAC (B) Specific Requirements for Certain Specialties/Services." This section explains that A/B MACs (B) must return claims as unprocessable if:

- The AA or CRNA is employed by a group (such as a hospital, physician, or Ambulatory Surgical Center [ASC]) and the group's name, address, and ZIP code, is not entered in item 33, or electronic equivalent the National Provider Identifier (NPI) is not entered in item 33a or electronic equivalent or the personal NPI of the nonphysician practitioner is not entered in item 24J or electronic equivalent.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to claims processing and payment for AA or CRNA services:

- 50: Payment for Anesthesiology Services
- 140: Qualified Nonphysician Anesthetist Services
- 140.1: Qualified Nonphysician Anesthetists
- 140.2: Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician Anesthetists
- 140.3: Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists
- 140.3.1: Conversion Factors Used on or After January 1, 1997 for Qualified Nonphysician Anesthetists
- 140.4.1: An Anesthesiologist and Qualified Nonphysician Anesthetist Work Together
- 140.4.2: Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure
- 140.4.3: Payment for Medical or Surgical Services Furnished by CRNAs
- 140.4.4: Conversion Factors for Anesthesia Services of Qualified Nonphysician Anesthetists Furnished on or After January 1, 1992
- 140.5: Payment for Anesthesia Services Furnished by a Teaching CRNA

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter II includes guidelines for coding anesthesia services by an AA or CRNA.

PHYSICIAN ASSISTANT

INTRODUCTION

This curriculum is designed as a pathway to Physician Assistant Medicare resources.

DEFINITION: PHYSICIAN ASSISTANT (PA)

In order to be enrolled in Medicare, a PA:

- Must be licensed by the State to practice as a PA, and either:
  - Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation); or
  - Passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Webpage – MLN Products – Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/APNPA.html
This webpage provides Medicare information and resources for Advanced Practice Registered Nurses (APRNs), Anesthesiologist Assistants (AAs), and PAs. APRNs include Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs).

Booklet – "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html
This booklet is designed to provide education on Medicare services furnished by certified registered nurse anesthetists, anesthesiologist assistants, nurse practitioners, certified nurse-midwives, clinical nurse specialists, and physician assistants. It includes the required qualifications, coverage criteria, billing, and payment for these provider types.

More Resources: Refer to the Physician and Other Enrolled Health Care Professionals pathway for additional information on providing non-physician practitioner services to Medicare beneficiaries.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 90.3, "Practitioners Defined." This section explains a PA may deliver covered Medicare services if there is specific authorization in State law.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare enrollment guidelines for a PA:

- 40.4: Definition of Physician/Practitioner
- 190: Physician Assistant (PA) Services

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf

Chapter 15, "Medicare Enrollment," includes the following sections which contain enrollment guidelines for a PA:

- 15.1.1: Definitions
- 15.1.2: Medicare Enrollment Application (CMS-855)
- 15.3: National Provider Identifier (NPI)
- 15.4.4.12: Physician Assistants (PAs)
- 15.5.2.6: Section 2 of the Form CMS-855I
- 15.10.1: Changes of Information – General Procedures
- 15.16.1: Ordering/Certifying Suppliers – Background
- 15.17: Establishing an Effective Date of Medicare Billing Privileges
- 15.21.7: Surety Bonds
- 15.27.1: Deactivations and Reactivations
- 15.27.2: Revocations

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf

Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which references Part B coverage of a PA.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf

Chapter 5, "Definitions," includes the following sections related to coverage for PA services:

- 10.1.1: Basic Commitment in Provider Agreement
- 90.3: Practitioners Defined

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf

Chapter 6, "Hospital Services Covered Under Part B," includes the following sections which explain PA coverage, who may order and perform diagnostic tests, as well as explain supervision of therapeutic services:

- 20.1.2: Exception to Limitation
- 20.4.5: Outpatient Diagnostic Services Under Arrangements

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections related to coverage of a PA providing and ordering services in an RHC or FQHC:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services

- 120: Services and Supplies Furnished Incident to Physician's Services
- 120.1: Provision of Incident to Services and Supplies
- 120.2: Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC
- 130: Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services
- 130.1: NP, PA, and CNM Requirements
- 130.2: Physician Supervision
- 140: Services and Supplies Incident to NP, PA, and CNM Services
- 170: Mental Health Visits
- 180: Physical and Occupational Therapy
- 220.1: Preventive Health Services in RHCs
- 220.3: Preventive Health Services in FQHCs

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare coverage for a PA:

- 60: Services and Supplies
- 60.1: Incident To Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.2: Psychological Tests and Neuropsychological Tests
- 80.5.4: Conditions for Coverage
- 80.6.1: Definitions
- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 190: Physician Assistant (PA) Services
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 250: Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities
- 280.2.2: Coverage Criteria
- 280.4: Screening Pap Smears
- 310.2: Qualified Person

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

Chapter 16, "General Exclusions From Coverage," includes Section 170, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider." This section explains that non-physician services provided to a Part A inpatient or Part B inpatient of a hospital or to a Part A inpatient of a Skilled Nursing Facility (SNF) which are not provided directly by the hospital/SNF or under arrangement generally are excluded from coverage under Medicare. This coverage exclusion does not apply to services by a PA.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes references to a PA in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 210.1: Prostate Cancer Screening Tests
- 210.2: Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to coverage for a PA's services:

- 30.6.1.1: Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
- 30.6.12: Critical Care Visits and Neonatal Intensive Care (Codes 99291 – 99292)
- 30.6.15.4: Power Mobility Devices (PMDs) (Code G0372)
- 100.1.7: Assistants at Surgery in Teaching Hospitals

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Chapter 18, "Preventive and Screening Services," includes the following sections which outline coverage for a PA providing certain preventive and screening services to Medicare beneficiaries:

- 30: Screening Pap Smears
- 50.1: Definitions
- 60.2: HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
- 80: Initial Preventive Physical Examination (IPPE)

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain Medicare billing for a PA:

- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 190: Physician Assistant (PA) Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," includes the following sections explaining billing for a PA's services:

- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.3: Carrier Rules for Limiting Charge
- 80.3.2.1.2: Conditional Data Element Requirements for A/B MACs and DME MACs
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to billing for a PA's services:

- 30.6.1: Selection of Level of Evaluation and Management Service

- 110.4: PA Billing to the A/B MAC (B)
- 180: Care Plan Oversight Services
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information," that explains a PA must accept assignment.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
Chapter 4, "Benefit Integrity," includes Section 4.20.2.1, "Civil Monetary Penalties Delegated to CMS." This section lists the authorities under which CMS' Program Integrity Group and the Office of Inspector General (OIG) may impose civil money penalties, assessments, and/or exclusions for program non-compliance in the event a PA bills on a non-assigned basis.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes section 130.3, "Payment to Physician Assistants" explaining Medicare payment for a PA in an RHC.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes section 190, "Physician Assistant (PA) Services" explaining Medicare payment for a PA.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to payment for a PA:

- 30.6.1: Selection of Level of Evaluation and Management Service
- 80.2: Rural Health Clinic and Federally Qualified Health Center Services
- 100.1.7: Assistants at Surgery in Teaching Hospitals
- 110: Physician Assistant (PA) Services Payment Methodology
- 110.1: Global Surgical Payments
- 110.2: Limitations for Assistant-at-Surgery Services Furnished by Physician Assistants
- 110.3: Outpatient Mental Health Treatment Limitation
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site
- 210: Outpatient Mental Health Treatment Limitation
- 210.1: Application of the Limitation
- 230.1: Definition of Primary Care Practitioners and Primary Care Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 20.2.1, "Categorical Denials." This section explains Medicare payment under the limitation on liability provision cannot be made because the actual Medicare payment denial is based on a categorical exclusion.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to services performed by a PA include:

Chapter I	General Correct Coding Policies
Chapter XI	Medicine, Evaluation and Management Services (CPT Codes 90000-99999)

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OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term physician assistant for related questions and answers. For example, FAQ3511 explains that physician assistants are allowed to provide the IPPE or the AWV.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The OIG has issued reports about health care providers, which includes a PA. Use the search feature on the home page of this website to review these.

AUDIOLOGIST

INTRODUCTION

This curriculum is designed as a pathway to Audiologist Medicare resources.

DEFINITION: AUDIOLOGIST

A qualified audiologist is defined by Medicare as an individual who has a master's or doctoral degree in audiology and is licensed as an audiologist by the State in which the individual furnishes such services, and that State's requirements meet or exceed Medicare's requirements.

If the person furnishes audiology services in a State that does not license audiologists, or is exempted from State licensure based on practice in a specific institution or setting, the person must meet one of the following conditions:

- Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; or
- Successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); and
- Performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field
- Successfully completed a national examination in audiology approved by Medicare.

Webpage – Physician Fee Schedule – Audiology Services

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Audiology.html
This webpage provides information on audiology services covered by Medicare, along with links to other audiology resources including a code list, manual references, and transmittals.

ENROLLMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain enrollment by an audiologist into the Medicare Program:

- 80.3: Audiology Services
- 80.3.1: Definition of Qualified Audiologist

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.4.2, "Audiologists."

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain coverage of audiology services:

- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.3: Audiology Services
- 230.3: Practice of Speech-Language Pathology

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions From Coverage," includes Section 100, "Hearing Aids and Auditory Implants," which addresses hearing aids and prosthetic devices such as cochlear implants.

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain billing for audiology services:

- 60: Services and Supplies
- 80.3: Audiology Services
- 80.6.1: Definitions
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.3: Practice of Speech-Language Pathology

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 30.3, "Audiology Services." This section provides billing information including appropriate use of National Provider Identifiers (NPIs), as well as coding and billing information related to audiological services and aural rehabilitation.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section includes instructions for billing services involving the testing of a hearing aid in order to obtain intentional denials when other payers are involved.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI includes guidelines for coding audiology services.

Document – Audiology Code List

https://www.cms.gov/Medicare/Billing/TherapyServices/downloads/Audiology_Codes.pdf
This document provides a list of audiology services by Current Procedural Terminology (CPT) code.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 30.3, "Audiology Services." This section explains the methods of payment for audiology services provided in an office setting and the professional services provided in a hospital outpatient setting.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 20.2.1, "Categorical Denials." This section explains that under the limitation on liability provision, the Medicare payment denial is made based on a statutory provision. Categorical exclusions related to an audiologist include hearing aids and hearing examinations.

CLINICAL SOCIAL WORKER

INTRODUCTION

This curriculum is designed as a pathway to Clinical Social Worker Medicare resources.

DEFINITION: CLINICAL SOCIAL WORKER (CSW)

A CSW as defined by Medicare must meet the following requirements:

- Possesses a master's or doctor's degree in social work
- After obtaining the degree, has performed at least 2 years of supervised clinical social work
- Either is licensed or certified as a clinical social worker by the State in which the services are performed or, in the case of an individual in a State that does not provide for licensure or certification as a clinical social worker:
  a. Is licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and
  b. Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting, such as a hospital, Skilled Nursing Facility (SNF), or clinic.

More Resources: Refer to the Physician and Other Enrolled Health Care Professionals pathway for additional information on providing general non-physician practitioner services to Medicare beneficiaries.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 90.3, "Practitioners Defined." This section explains Medicare covers CSW services without direct physician supervision.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare enrollment guidelines for a CSW:

- 40.4: Definition of Physician/Practitioner
- 170: Clinical Social Worker (CSW) Services

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections outlining the qualifications a CSW must meet to enroll in the Medicare Program:

- 15.4.4.7: Clinical Social Workers
- 15.4.8: Suppliers Not Eligible to Participate
- 15.5.2.6: Section 2 of the Form CMS-855I

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which references Part B coverage of CSWs.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections related to a CSW providing services in an RHC or FQHC:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services
- 150: Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services
- 160: Services and Supplies Incident to CP and CSW Services
- 170: Mental Health Visits
- 220.3: Preventive Health Services in FQHCs

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 170, "Clinical Social Worker (CSW) Services," which explains coverage for the services of a CSW.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 19

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf
Chapter 19, "Indian Health Services," includes Section 70, "Covered Medicare Part B Services That May Be Paid to IHS Providers, Physicians and Practitioners." This section explains Medicare Part B covers medically necessary expenses incurred for a CSW.

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain billing for a CSW:

- 60: Services and Supplies
- 60.1: Incident To Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 170: Clinical Social Worker (CSW) Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections requiring mandatory assignment for a CSW:

- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12: Carrier Annual Participation Program
- 30.3.12.1: Annual Open Participation Enrollment Process

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 190.6, "Payment Methodology for Physician/Practitioner at the Distant Site." This section explains a CSW may bill for telehealth services, subject to State law. This section also explains a CWS cannot bill for psychotherapy services that include medical evaluation and management services under Medicare.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," includes Section 30, "Outpatient Mental Health Treatment Limitation." This section explains the outpatient mental health limitation and how it will be phasing out.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes section 170, "Clinical Social Worker (CSW) Services" explaining Medicare payment for a CSW.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections which explain payment for a CSW:

- 150: Clinical Social Worker (CSW) Services
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site
- 210: Outpatient Mental Health Treatment Limitation
- 210.1: Application of the Limitation

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
Chapter 4, "Benefit Integrity," includes Section 4.20.2.1, "Civil Monetary Penalties Delegated to CMS." This section lists the authorities under which the Centers for Medicare & Medicaid Services' (CMS') Program Integrity Group and the Office of Inspector General (OIG) may impose civil money penalties, assessments, and/or exclusions for program non-compliance in the event a CSW bills on a non-assigned basis.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI, "Medicine, Evaluation and Management Services (CPT Codes 90000-99999)," includes coding information relevant to services performed by a CSW.

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OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term social worker for related questions and answers. For example, FAQ2357 explains how some social worker calls may be reported to Medicare as hospice services.

Electronic Mailing List – Social Worker

https://list.nih.gov/cgi-bin/wa.exe?A0=nimh_irp_social_work
The electronic mailing list NIMH_IRP_SOCIAL_WORK@LIST.NIH.GOV is administered by CMS and is for National Institute of Mental Health Intramural Research Program (NIMH IRP) social workers to share information, professional resources, support, and network with each other.

Beneficiary Booklet – "Medicare & Your Mental Health Benefits"

https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf
This beneficiary booklet is the official government booklet about mental health benefits for Fee-For-Service Medicare beneficiaries. A CSW treating Medicare beneficiaries may refer them to this resource.

PSYCHOLOGIST: CLINICAL AND INDEPENDENTLY PRACTICING

INTRODUCTION

This curriculum is designed as a pathway to Psychologist: Clinical and Independently Practicing Medicare resources.

Definition: Clinical Psychologist (CP)

A clinical psychologist is defined by Medicare as a person who:

- Holds a doctoral degree in psychology
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals

Definition: Independently Practicing Psychologist (IPP)

An independently practicing psychologist is defined by Medicare as a person who:

- Is licensed or certified to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. (It is the understanding of the Centers for Medicare & Medicaid Services [CMS] that all States, the District of Columbia, and Puerto Rico license psychologists, but that some trust territories do not. Examples of psychologists, other than CPs, whose psychological and neuropsychological tests are covered under the diagnostic tests provision include, but are not limited to, educational psychologists and counseling psychologists.)

The Medicare Contractor considers psychologists as practicing independently when:

- They render services on their own responsibility, free of the administrative and professional control of an employer such as a physician, institution, or agency
- The persons they treat are their own patients
- They have the right to bill directly, collect, and retain the fee for their services

A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions exist:

- The office is confined to a separately-identified part of the facility which is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution
- The psychologist conducts a private practice that is, services are rendered to patients from outside the institution as well as to institutional patients

More Resources: Refer to the Physician and Other Enrolled Health Care Professionals pathway for additional information on providing general non-physician practitioner services to Medicare beneficiaries.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 90.3, "Practitioners Defined." This section explains a CP may deliver services without direct physician supervision.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining Medicare enrollment guidelines for a CP:

- 40.4: Definition of Physician/Practitioner
- 160: Clinical Psychologist Services

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections outlining qualifications a CP and a psychologist practicing independently must meet to enroll in the Medicare Program:

- 15.4.4.6: Clinical Psychologists
- 15.4.4.13: Psychologists Practicing Independently
- 15.5.2.6: Section 2 of the Form CMS-855I

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which references Part B coverage of a qualified psychologist.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6 – "Hospital Services Covered Under Part B," includes the following sections which explain covered psychiatric care Medicare beneficiaries may receive from a CP or a psychologist:

- 20.3: Encounter Defined
- 20.4.4: Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010
- 20.4.5: Outpatient Diagnostic Services Under Arrangements
- 20.5.2: Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010
- 40: Other Covered Services and Items
- 70.1: General
- 70.3: Partial Hospitalization Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections related to a CP providing services in an RHC or FQHC:

- 10.1: RHC General Information
- 10.2: FQHC General Information

- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services
- 150: Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services
- 160: Services and Supplies Incident to CP and CSW Services
- 170: Mental Health Visits

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining coverage relevant to a CP or an independently practicing psychologist:

- 80.2: Psychological Tests and Neuropsychological Tests
- 160: Clinical Psychologist Services

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to mental health in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf

- 130.1: Inpatient Hospital Stays for the Treatment of Alcoholism
- 130.2: Outpatient Hospital Services for Treatment of Alcoholism

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes these sections which explain Medicare Part B coverage and billing for a CP in a partial hospitalization setting:

- 260.1: Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
- 260.1.1: Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)
- 260.3: Outpatient Mental Health Treatment Limitation for Partial Hospitalization Services

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain billing for a CP or an independently practicing psychologist:

- 60: Services and Supplies
- 60.1: Incident To Physician's Professional Services
- 60.2: Services of Nonphysician Personnel Furnished Incident To Physician's Services
- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.2: Psychological Tests and Neuropsychological Tests
- 160: Clinical Psychologist Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections requiring mandatory assignment for a CP:

- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12.1: Annual Open Participation Enrollment Process

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," includes Section 90.5, "Definition of Diagnostic Services." These diagnostic services include psychological tests.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes the following sections which explain Medicare Part B billing for partial hospitalization services that may be provided by a CP:

- 260.1: Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
- 260.2: Professional Services Related to Partial Hospitalization
- 260.3: Outpatient Mental Health Treatment Limitation for Partial Hospitalization Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section explains claims for a CP can only be paid on an assigned basis.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," includes Section 30, "Outpatient Mental Health Treatment Limitation." This section explains the outpatient mental health limitation and how it will be phasing out.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes section 160, "Clinical Psychologist Services" which explains payment for a CP's services.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections which explain payment for a CP or an independently practicing psychologist:

- 20.4.2: Site of Service Payment Differential
- 160: Independent Psychologist Services
- 160.1: Payment
- 170: Clinical Psychologist Services
- 170.1: Payment
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site

- 210: Outpatient Mental Health Treatment Limitation
- 210.1: Application of the Limitation

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 20.2.1, "Categorical Denials." This section explains Medicare payment under the limitation on liability provision cannot be made because the actual Medicare payment denial is based on a categorical exclusion. This includes physicians' services performed by a psychologist when furnished to an inpatient, unless they are furnished under arrangement with the hospital.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
Chapter 4, "Benefit Integrity," includes Section 4.20.2.1, "Civil Monetary Penalties Delegated to CMS." This section lists the authorities under which CMS' Program Integrity Group and the Office of Inspector General (OIG) may impose civil money penalties, assessments, and/or exclusions for program non-compliance in the event a CP bills on a non-assigned basis.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI, "Medicine, Evaluation and Management Services (CPT Codes 90000-99999)," includes coding information relevant to psychiatric services performed by a CP or an independently practicing psychologist.

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OTHER RESOURCES

Other helpful, official resources are included in this section.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Exhibits, Exhibit 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83exhibits.pdf
Exhibit 25, "Procedures and Forms for Obtaining Protected Health Information," includes a Patient Authorization to Release Psychotherapy Information form for representatives of the United States Attorney's Office or Department of Justice. A CP or independently practicing psychologist may see this form when used to obtain medical records in law enforcement and health oversight investigations.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term psychologist or mental health for related questions and answers. For example, FAQ2415 addresses if CPT codes for psychological and neuropsychological tests include tests performed by technicians and computers.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The OIG website includes reports on subjects such as payments for mental health services in nursing facilities and Medicare coverage of and payment for mental health services. Use the search feature on the home page of this website to review these.

Electronic Mailing List – Mental Health

https://list.nih.gov/cgi-bin/wa.exe?A0=global_mental_health
The electronic mailing list GLOBAL_MENTAL_HEALTH@LIST.NIH.GOV is administered by CMS and provides resources for investigators, Federal employees, and other members of the public on research and training opportunities in global mental health.

Beneficiary Booklet – "Medicare & Your Mental Health Benefits"

https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf
This beneficiary booklet is the official government booklet about mental health benefits for Fee-For-Service Medicare beneficiaries. A CP or an independently practicing psychologist may refer a Medicare beneficiary to this resource.

OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST, AND SPEECH-LANGUAGE PATHOLOGIST

INTRODUCTION

This curriculum is designed as a pathway to Occupational Therapist, Physical Therapist, and Speech-Language Pathologist in private practice Medicare resources. Private practice includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider. The contractor considers a therapist to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or the beneficiary's home. Or, a therapist is employed by another supplier and furnishes services in facilities provided at the expense of that supplier.

Definition: Occupational Therapist (OT)

A qualified OT is an individual who meets one of the following requirements:

- Is a graduate of an OT curriculum accredited jointly by the Committee on Allied Health Education of the American Medical Association and the American Occupational Therapy Association; or
- Is eligible for the National Registration Examination of the American Occupational Therapy Association; or
- Has 2 years of appropriate experience as an OT, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an OT after December 31, 1977.

Definition: Occupational Therapy

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

Definition: Physical Therapist (PT)

A qualified PT is a person who is licensed as a PT by the State in which he or she is practicing and meets one of the following requirements:

- Has graduated from a PT curriculum approved by the American Physical Therapy Association (APTA), the Committee on Allied Health Education and Accreditation of the American Medical Association, or the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or
- Prior to January 1, 1966, met one of the following:
  - Was admitted to membership by the APTA;
  - Was admitted to registration by the American Registry of Physical Therapists;
  - Has graduated from a 4-year PT curriculum approved by a State Department of Education; or
  - Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970 had 15 years of full-time experience in PT under the order and direction of attending and referring doctors of medicine or osteopathy; or
  - Has 2 years appropriate experience as a PT and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the Public Health Service, except such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a PT after December 31, 1977; or
  - If trained outside the United States and graduated since 1928 from a PT therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy and meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

Definition: Physical Therapy

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities, or changes in physical function and health status.

Definition: Speech-Language Pathologist (SLP)

A qualified SLP for Medicare Program coverage purposes must meet the following requirements:

- Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of SLP by the State in which the SLP practices, and practice only within the scope of the SLP's license and/or certification.
- Engage in the private practice of SLP as an individual, in one of the following practice types:
  - An unincorporated solo practice;
  - An unincorporated partnership or unincorporated group practice;
  - An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated SLP practice;
  - An employee of a physician group; or
  - An employee of a group that is not a professional corporation.

Definition: Speech-Language Pathology

Speech-language pathology services are those services provided within the scope of practice of SLPs and necessary for the diagnosis and treatment of speech and language disorders.

More Resources: For additional information on providing occupational therapy, physical therapy, or speech-language pathology services to Medicare beneficiaries, refer to various pathways such as Outpatient Physical Therapy, Other Rehabilitation, and Outpatient Speech Pathology Facility, Hospital, Home Health Agency, or the Skilled Nursing Facility.

ENROLLMENT

Webpage – CMS Forms

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
This webpage provides links to the Centers for Medicare & Medicaid Services (CMS) enrollment forms, including the Form CMS-855B for enrollment as a physical/occupational therapy group in a private practice and the Form CMS-855I to enroll as an OT, a PT, or a SLP in private practice. The Form CMS-855A is used for enrollment to provide outpatient physical therapy/occupational therapy/speech pathology services in the outpatient setting. Enter the form 855 in the Filter On box.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain the qualifications for an OT, PT, or SLP to enroll in Medicare:

- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology

- 230.4: Services Furnished by a Therapist in Private Practice (TPP)

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections related to the definition of terms used in the Medicare enrollment process and the requirements an OT, PT, or SLP must meet in order to enroll in Medicare:

- 15.1.1: Definitions
- 15.3: National Provider Identifier (NPI)
- 15.4.4.9: Occupational Therapists in Private Practice
- 15.4.4.10: Physical Therapists in Private Practice
- 15.4.4.15: Speech Language Pathologists in Private Practice
- 15.5.2.5: Section 2 of the Form CMS-855B
- 15.5.2.6: Section 2 of the Form CMS-855I
- 15.21.7: Surety Bonds

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following chapters related to coverage of an OT, PT, or a SLP:

- 10.3: Under Arrangements
- 90.1: Supplier Defined

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes Section 180, "Physical and Occupational Therapy," related to providing PT or OT services in an RHC or FQHC.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain coverage for an OT, PT, or SLP:

- 80.2: Psychological Tests and Neuropsychological Tests
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 220.1: Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.2: Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 220.2: Reasonable and Necessary Outpatient Rehabilitation Therapy Services
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology
- 230.4: Services Furnished by a Therapist in Private Practice (TPP)
- 230.5: Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Nonphysician Practitioners (NPP)

- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes a reference to an OT, a PT, or a SLP in a specific NCD. There might be other NCDs of interest in these manuals. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 50.1: Speech Generating Devices
- 50.2: Electronic Speech Aids
- 50.3: Cochlear Implantation (Effective April 4, 2005)
- 50.4: Tracheostomy Speaking Valve

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf

- 160.7.1: Assessing Patients Suitability for Electrical Nerve Stimulation Therapy
- 160.12: Neuromuscular Electrical Stimulator (NMES)

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf

- 170.2: Melodic Intonation Therapy
- 170.3: Speech-Language Pathology Services for the Treatment of Dysphagia

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 240.7: Postural Drainage Procedures and Pulmonary Exercises
- 270.1: Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds – (Effective July 1, 2004)

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html

This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

More Resources: Refer to other pathways such as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Home Health Agency (HHA), and Hospice for additional information about OTs, PTs, and SLPs.

BILLING

Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
Medicare Part B provides coverage for many types of therapy services. Medicare will apply therapy caps and exceptions, as appropriate. This webpage provides annual therapy updates and includes hyperlinks to CMS manuals and Change Requests (CRs) related to therapy services.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

Website – eGlobalTech (eGT)

http://www.cbrinfo.net
This website provides the most recent Comparative Billing Reports (CBR) with links to past and upcoming webinars, teleconferences and samples for that specific CBR. A CBR is a documented analysis that shows a provider's billing pattern for various procedures or services and compares that billing to their peers. Sample reports are available for podiatry, electrodiagnostic studies, ambulance, diabetic testing supplies, nebulizer drugs, orthoses, and positive airway pressure (PAP).

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to billing for an OT, PT, or SLP:

- 220.3: Documentation Requirements for Therapy Services
- 220.4: Functional Reporting
- 230.4: Services Furnished by a Therapist in Private Practice (TPP)
- 230.5: Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Nonphysician Practitioners (NPP)
- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections explaining billing guidelines for an OT, PT, or SLP:

- 30.2.8.3: Indirect Payment Procedure (IPP) – Payment to Entities that Provide Coverage Complementary to Medicare Part B
- 30.2.13: Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment – for A/B MAC (B) Processed Claims
- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12: Carrier Annual Participation Program
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.3: Carrier Rules for Limiting Charge
- 50.1.2: Beneficiary Request for Payment on Provider Record – ASC X12 837 Institutional Claim Format and Form CMS 1450

- 70.8: Filing Request for Payment to Carriers – Medicare Part B
- 70.8.1: Splitting Claims for Processing
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services
- 180.1: Background and Policy

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections related to billing for an OT, PT, or SLP:

- 10: Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General
- 10.5: Notification for Beneficiaries Exceeding Financial Limitations
- 10.6: Functional Reporting

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes the following sections related to billing for an OT, PT, or SLP:

- 10.4: Items 14-33 – Provider of Service or Supplier Information
- 10.5: Place of Service Codes (POS) and Definitions
- 10.7: Type of Service (TOS)
- 10.8.3: Nonphysician Practitioner, Supplier, and Provider Specialty Codes

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections related to payment for OT, PT, and SLP services:

- 10.3: Application of Financial Limitations
- 10.4: Claims Processing Requirements for Financial Limitations
- 10.7: Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes the following sections related to payment for an OT or a PT:

- 20.1: Method for Computing Fee Schedule Amount
- 20.2: Relative Value Units (RVUs)
- 20.4.1: Participating Versus Nonparticipating Differential
- 30.6.1: Selection of Level of Evaluation and Management Service
- 90.4.5: Services Eligible for HPSA and Physician Scarcity Bonus Payments

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes the following sections related to payment for an OT, PT, or SLP:

- 30: Services Paid Under the Medicare Physician's Fee Schedule
- 100.5: Adjustments to the Single Payment Amounts to Reflect Changes in HCPCS Codes

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

MLN Matters® Article – MM8206 Revised "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8206.pdf
This MLN Matters® article informs Medicare Contractors that the MPPR on selected therapy services was increased to 50 percent for both office and institutional settings effective for claims with dates of service on or after April 1, 2013. The therapy services include OT, PT, and SLP.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term therapy for related questions and answers. For example, FAQ2001 explains the history and current use of therapy caps for outpatient therapy services.

Webpage – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports on occupational and physical therapy services. Use the search feature on the home page of this website to review these.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Occupational therapy, physical therapy, and speech-language pathology services are considered DHS.

Beneficiary Publication – Medicare Limits on Therapy Services

https://www.medicare.gov/Pubs/pdf/10988.pdf

This beneficiary publication explains the annual Medicare limits for medically-necessary outpatient physical therapy, speech-language pathology, and occupational therapy. Other helpful, official resources are included in this section.

Electronic Mailing Lists – Therapy Services

https://list.nih.gov/searchlsv.html

- https://list.nih.gov/cgi-bin/wa.exe?A0=usphs_therapist
  The U.S. Public Health Service (USPHS) Therapist electronic mailing list is administered by CMS and is used to distribute information for an OT, a PT, a SLP, and audiologists.
- https://list.nih.gov/cgi-bin/wa.exe?A0=therapy-caps-l
  The Therapy Cap electronic mailing list is administered by CMS, which emails subscribers information regarding therapy caps.

REGISTERED DIETITIAN OR NUTRITION PROFESSIONAL

INTRODUCTION

This curriculum is designed as a pathway to Registered Dietitian or Nutrition Professional Medicare resources.

DEFINITION: REGISTERED DIETITIAN OR NUTRITION PROFESSIONAL

A registered dietitian or nutrition professional as defined by Medicare is an individual who, on or after December 22, 2000:

1. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose;
2. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and
3. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a registered dietitian by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs 1 and 2 above.

There are two caveats to these requirements:

- A dietitian or nutritionist licensed or certified in a State as of December 21, 2000, is not required to meet the requirements of 1 and 2 above.
- A dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of 1 and 2 above.

ENROLLMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes Section 300.3, "Dietitians and Nutritionists Performing MNT Services." This section explains enrollment guidelines for a registered dietitian or a nutrition professional.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections which provide enrollment guidelines for a registered dietitian or a nutrition professional:

- 15.4.4.14: Registered Dietitians
- 15.4.6.1: Diabetes Self-Management Training (DSMT)
- 15.5.2.5: Section 2 of the Form CMS-855B
- 15.8.4: Denials
- 15.10.1: Changes of Information – General Procedures
- 15.17: Establishing an Effective Date of Medicare Billing Privileges
- 15.21.7: Surety Bonds
- 15.27.1: Deactivations and Reactivations
- 15.27.2: Revocations

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description." This section explains coverage for Medical Nutrition Therapy (MNT) services in the case of a beneficiary who meets certain criteria determined after consideration of protocols established by dietitian or nutrition professional organizations. It also explains DSMT services are covered under Part B.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
Chapter 11, "End Stage Renal Disease (ESRD)," includes the following sections which explain coverage of a dietitian when treating beneficiaries in an ESRD facility:

- 10: Definitions Relating to ESRD
- 20: Renal Dialysis Items and Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," includes the following sections which explain coverage for DSMT and MNT:

- 10.2: FQHC General Information
- 40: RHC and FQHC Visits
- 50.2: FQHC Services
- 220.1: Preventive Health Services in RHCs
- 220.3: Preventive Health Services in FQHCs

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections explaining coverage for a registered dietitian or a nutrition professional and the services they can perform:

- 40.4: Definition of Physician/Practitioner
- 280.5: Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS)
- 300: Diabetes Self-Management Training Services
- 300.2: Certified Providers

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to diet or nutrition related to services that may be provided by a registered dietitian or a nutrition professional in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 20.31.1: The Pritikin Program (Effective August 12, 2010)

- 20.31.2: Ornish Program for Reversing Heart Disease (Effective August 12, 2010)
- 40.1: Diabetes Outpatient Self-Management Training

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf
- 180.1: Medical Nutrition Therapy

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 280.14: Infusion Pumps

More Resources: Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) pathway for information about Parenteral and Enteral Nutrition (PEN).

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes the following sections explaining coverage for MNT by a registered dietitian or a nutrition professional:
- 300: Medical Nutrition Therapy (MNT) Services
- 300.1: General Conditions and Limitations on Coverage
- 300.2: Referrals for MNT Services
- 300.3: Dietitians and Nutritionists Performing MNT Services

More Resources: Refer to the CMS Preventive Services Provider Resources webpage at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html for additional information regarding preventive services for Medicare beneficiaries; for example, MNT and the AWV.

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
Chapter 7, "Home Health Services," includes Section 80.9, "Dietary and Nutrition Personnel." This section explains if dietitians or nutritionists are used to furnish overall training or consultative advice to Home Health Agency (HHA) staff and incidentally furnish dietetic or nutritional services to beneficiaries in their homes, the costs of these professional services are allowable only as administrative costs. Visits by a dietician or nutritionist to a beneficiary's home are not separately billable.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections which explain a registered dietician or a nutrition professional must accept assignment:
- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12.1: Annual Open Participation Enrollment Process

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Although Chapter 4 is called "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," it includes the following sections which explain billing for MNT services by a registered dietitian or a nutrition professional:

- 300.3: Dietitians and Nutritionists Performing MNT Services
- 300.4: Payment for MNT Services
- 300.5: General Claims Processing Information
- 300.5.1: RHCs/FQHCs Special Billing Instructions

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 190.6, "Payment Methodology for Physician/Practitioner at the Distant Site." This section explains a registered dietitian or a nutrition professional may bill for telehealth services, subject to State law.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections explaining billing for DSMT and the AWV:

- 120.1: Coding and Payment of DSMT Services
- 120.2.2: Advance Beneficiary Notice (ABN) Requirements
- 140.1: Healthcare Common Procedure Coding System (HCPCS) Coding for the AWV
- 140.2: A/B Medicare Administrative Contractor (MAC) and Carrier Billing Requirements
- 140.5: Coinsurance and Deductible

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI includes guidelines for coding MNT services.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes the following sections which explain claims processing and payment for a registered dietitian or a nutrition professional in a hospital:

- 240: Inpatient Part B Hospital Services
- 300.4: Payment for MNT Services
- 300.5: General Claims Processing Information
- 300.6: Common Working File (CWF) Edits

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections explaining payment for outpatient DSMT or the AWV:

- 120.1: Coding and Payment of DSMT Services
- 120.2.1: Special Processing Instructions for Billing Frequency Requirements
- 140: Annual Wellness Visit (AWV)

- 140.6: Common Working File (CWF) Edits
- 140.7: Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes Section 300.6, "Common Working File (CWF) Edits." This section explains the beneficiary may be liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the registered dietitian or nutrition professional will be held liable.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Electronic Mailing List – Nutrition Frontiers

https://list.nih.gov/cgi-bin/wa.exe?A0=nutritionfrontiers
The Nutrition Science Research Group electronic mailing list is administered by CMS, which emails subscribers a newsletter of the Nutritional Science Research Group, a Division of Cancer Prevention, NCI. The newsletter is available through NUTRITIONFRONTIERS@LIST.NIH.GOV.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term nutrition for related questions and answers. For example, FAQ2695 explains a registered dietitian or a nutrition professional can opt out of Medicare and provide services to Medicare beneficiaries through private contracts.

SUPPLIERS

Definition: Supplier

For the purpose of the Medicare Learning Network® (MLN) Guided Pathways, a supplier is an entity which enrolls on the Form CMS-855B or Form CMS-855S (or the Internet-based Provider Enrollment, Chain and Ownership System [PECOS]). However, please note the legal Medicare definition of supplier is any entity other than a provider (which enrolls on Form CMS-855A or the Internet-based PECOS).

Some suppliers, such as ambulance and laboratory, when operated by a hospital, do not enroll as a supplier. Their services would be considered included in what is provided by the enrolled hospital.

More Resources: Most suppliers who are listed on the Forms CMS-855B and CMS-855S have separate pathways with information of specific relevance.

Webpage – Medicare Provider-Supplier Enrollment

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html
This webpage includes an Enrollment Applications link for more information on enrollment forms including the Form CMS-855S, the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier enrollment application. Certain other suppliers and organizations/groups complete the Form CMS-855B. This page also includes links to information about enrolling through the Internet-based PECOS.

AMBULANCE SERVICE PROVIDER AND SUPPLIER

INTRODUCTION

This curriculum is designed as a pathway to Ambulance Service Provider and Supplier Medicare resources. Unless information is specifically listed under the provider or supplier headings, the content refers to ambulance services by both providers and suppliers.

Definition: Ambulance Service

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must seek payment from the provider who is responsible for the beneficiary's care.

Medicare Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

- Actual transportation of the beneficiary occurs
- The beneficiary is transported to an appropriate destination
- The transportation by ambulance must be medically necessary, meaning the beneficiary's medical condition is such that other forms of transportation are medically contraindicated
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements
- The transportation is not part of a Part A service

Provider

The term provider is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, Critical Access Hospital (CAH), Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Home Health Agency (HHA), hospice program, or, for purposes of Medicare, a fund.

Supplier

The term supplier is defined as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, or a local government-run firehouse-based ambulance that provides Part B Medicare covered ambulance services and is enrolled as an independent ambulance supplier.

Webpage – Ambulance Services Center

https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html
The Ambulance Services Center provides links to coding/billing/payment, enrollment, education, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations, Medicare Secondary Payer (MSP), and National Provider Identifier (NPI) information specific to ambulance providers and suppliers.

Booklet – "Medicare Ambulance Transports"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1249521.html
Learn about the ambulance transport benefit; ambulance transports; ground and air ambulance providers and suppliers, vehicles, and personnel requirements; documentation requirements; coverage, billing, and payments; and Advance Beneficiary Notice of Noncoverage.

ENROLLMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 19

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf
Chapter 19, "Indian Health Services," includes Section 40.1.6, "Clinical Laboratory, Ambulance and Medicare Part B Drugs." This section explains that Indian Health Services (IHS), tribe, and tribal organization facilities providing ambulance services must meet all of the usual enrollment requirements for the designated Medicare Administrative Contractor for Medicare enrollment.

SUPPLIERS ONLY

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections related to enrollment in the Medicare Program to provide ambulance services:

- 15.3: National Provider Identifier (NPI)
- 15.5.4.2: Section 4 of the Form CMS-855B
- 15.5.18: Ambulance Attachment

Form – Medicare Enrollment Application Form CMS-855B

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf
Ambulance service suppliers must complete Attachment 1 of the Form CMS-855B. The attachment requires completion of a valid Federal Aviation Administration (FAA) 135 Certificate for aircraft being used as an air ambulance.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes the following sections explaining the physician certification statement for ambulance transports:

- 20: Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
- 40.2: Certification for Extended Care Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," includes Section 10, "Medical and Other Health Services Furnished to Inpatients of Participating Hospitals." This section explains payment may be made under Part B for ambulance services when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf
Chapter 10, "Ambulance Services," includes the following sections which explain Medicare coverage for land and air ambulance services:

- 10: Ambulance Service
- 10.1.1: The Vehicle

- 10.1.2: Vehicle Requirements for Basic Life Support and Advanced Life Support
- 10.1.3: Verification of Compliance
- 10.1.5: Equipment and Supplies
- 10.2: Necessity and Reasonableness
- 10.2.1: Necessity for the Service
- 10.2.3: Medicare Policy Concerning Bed-Confinement
- 10.2.4: Documentation Requirements
- 10.2.6: Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports
- 10.3: The Destination
- 10.3.1: Institution to Beneficiary's Home
- 10.3.2: Institution to Institution
- 10.3.3: Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service
- 10.3.4: Transports to and from Medical Services for Beneficiaries who are not Inpatients
- 10.3.5: Locality
- 10.3.6: Appropriate Facilities
- 10.3.8: Ambulance Service to Physician's Office
- 10.3.9: Transportation Requested by Home Health Agency
- 10.4: Air Ambulance Services
- 10.4.1: Coverage Requirements
- 10.4.2: Medical Reasonableness
- 10.4.3: Time Needed for Ground Transport
- 10.4.4: Hospital to Hospital Transport
- 10.4.5: Special Coverage Rule
- 10.4.6: Special Payment Limitations
- 10.4.9: Effect of Beneficiary Death on Program Payment for Air Ambulance Transports
- 20: Coverage Guidelines for Ambulance Service Claims
- 20.1.2: Beneficiary Signature Requirements
- 30.1.1: Ground Ambulance Services
- 30.1.2: Air Ambulance Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections which explain coverage for ambulance services:

- 10: Supplementary Medical Insurance (SMI) Provisions
- 250: Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities
- 260.4: Coverage of Services in ASCs, Which are Not ASC Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions From Coverage," includes the following sections which explain coverage or non-coverage for ambulance services:

- 40.6: Ambulance Services
- 60: Services Not Provided Within United States
- 170: Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

Chapter 15, "Ambulance," includes the following sections outlining the coverage of medically necessary ambulance services and beneficiary transportation:

- 10.1.1: Statutes and Regulations
- 10.1.2: Other References to Ambulance Related Policies in the CMS Internet Only Manuals (IOM)
- 10.2: Summary of the Benefit
- 10.3: Definitions
- 10.4: Additional Introductory Guidelines

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf
Chapter 4, "Benefits and Beneficiary Protections," includes the following sections which explain coverage for ambulance services under Medicare Advantage (MA):

- 20.1: Ambulance Services
- 20.2: Definitions of Emergency and Urgently Needed Services
- 20.3: MAO Responsibilities for Coverage of Emergency Services
- 20.4: Stabilization of an Emergency Medical Condition
- 20.5: Post-Stabilization Care Services

Document – "Guidance on Beneficiary Signature Requirements for Ambulance Claims"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Guidance_on_Beneficiary_Signature_Requirements_for_Ambulance_Claims.pdf
This CMS policy statement explains beneficiary signature requirements for ambulance transport services.

Providers Only

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 1, "Definition of Inpatient Hospital Services." This section explains the term 'inpatient hospital or inpatient CAH services' includes ambulance transportation services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital.

Suppliers Only

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.2.7, "Suppliers of Ambulance Services," which explains Medicare Part B coverage of ambulance services, including fixed wing and rotary wing ambulance services.

BILLING

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description." This section explains that ambulance service is covered where the use of other methods of transportation is contraindicated by the beneficiary's condition, but only to the extent provided in regulations.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf
Chapter 10, "Ambulance Services," includes the following sections which explain Medicare billing procedures for ambulance services:

- 10.3.3: Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service
- 10.5: Joint Responses
- 20.1: Mandatory Assignment Requirements
- 20.1.1: Managed Care Providers/Suppliers
- 20.1.2: Beneficiary Signature Requirements
- 30.1.2: Air Ambulance Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections explaining billing for ambulance providers or suppliers:

- 10: Jurisdiction for Claims
- 10.1: Carrier Jurisdiction of Requests for Payment
- 10.1.1: Payment Jurisdictions Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services
- 10.1.5.3: Ambulance Services Submitted to Carriers
- 10.2: FI Jurisdiction of Requests for Payment
- 30.3.1: Mandatory Assignment on Carrier Claims
- 60.4.2: Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf
Chapter 15, "Ambulance," includes Section 40, "Medical Conditions List and Instructions," which will help ambulance providers and suppliers communicate the beneficiary's condition to Medicare Contractors.

IOM – "One-Time Notification," Pub. 100-20, Transmittal 1003

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1003OTN.pdf
Transmittal 1003, "Instructions to Accept and Process All Ambulance Transportation Healthcare Common Procedure Coding System (HCPCS) Codes," notifies providers and suppliers that effective January 1, 2012, they are able to submit no-pay claims to Medicare for statutorily excluded ambulance transportation services and transportation related services, in order to obtain a Medicare denial to submit a beneficiary's secondary insurance for coordination of benefits purposes.

Providers Only

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf
Chapter 15, "Ambulance," provides payment rules, general billing guidelines, and medical conditions for different levels of ambulance transport. The following sections are related specifically to ambulance billing by providers:

- 30.1.4: CWF Editing of Ambulance Claims for Inpatients
- 30.2: Fiscal Intermediary Shared System (FISS) Guidelines
- 30.2.1: A/B MAC (A) Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation
- 30.2.2: SNF Billing
- 30.2.3: Indian Health Services (IHS)/Tribal Billing
- 30.2.4: Non-covered Charges on Institutional Ambulance Claims

MLN Matters® Article – SE0433 Revised "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0433.pdf
This Special Edition MLN Matters® article describes SNF Consolidated Billing as it applies to ambulance services for SNF residents.

Suppliers Only

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf
Chapter 15, "Ambulance," provides payment rules, general billing guidelines, and medical conditions for different levels of ambulance transport. The following sections are related to ambulance billing by suppliers:

- 10.3: Definitions
- 30: General Billing Guidelines
- 30.1: Multi-Carrier System (MCS) Guidelines
- 30.1.1: MCS Coding Requirements for Suppliers
- 30.1.2: Coding Instructions for Paper and Electronic Claim Forms
- 30.1.3: Coding Instructions for Form CMS-1491

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section outlines billing requirements for an ambulance supplier using the Form CMS-1500 or electronic equivalent.

Booklet – "Medicare Ambulance Transports"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1249521.html
Learn about the ambulance transport benefit; ambulance transports; ground and air ambulance providers and suppliers, vehicles, and personnel requirements; documentation requirements; coverage, billing, and payments; and Advance Beneficiary Notice of Noncoverage.

MLN Matters® Article – SE1029 Revised "5010 Requirement for Ambulance Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1029.pdf
This Special Edition MLN Matters® article explains that for claims submitted in the version 5010 837P electronic claim format, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement. This article advises ambulance suppliers how to submit their claims electronically in light of this requirement.

CLAIMS PROCESSING AND PAYMENT

Webpage – Ambulance Fee Schedule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html
This webpage provides information on the Ambulance Fee Schedule (AFS), AFS public use files, Ambulance Reasonable Charge public use files, AFS regulations and notices, multiple zip code files, and transmittals.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf
Chapter 10, "Ambulance Services," includes the following sections which explain Medicare payment for land and air ambulance services:

- 10: Ambulance Service
- 10.1.4: Ambulance Services Furnished by Providers of Services
- 10.1.5: Equipment and Supplies
- 10.2.2: Reasonableness of the Ambulance Trip
- 10.2.5: Transport of Persons Other Than the Beneficiary
- 10.3.7: Partial Payment
- 10.3.10: Multiple Patient Ambulance Transport
- 10.4.6: Special Payment Limitations
- 10.4.7: Documentation
- 10.4.8: Air Ambulance Transports Canceled Due to Weather or Other Circumstances Beyond the Pilot's Control
- 10.4.9: Effect of Beneficiary Death on Program Payment for Air Ambulance Transports
- 30: Implementation of the Ambulance Fee Schedule
- 30.1: Definition of Ambulance Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf
Chapter 15, "Ambulance," includes the following sections explaining payment rules under the Medicare AFS, components of the payment amount (such as mileage), or specialized payment amounts (for example, air ambulance) for providers and suppliers:

- 10.3: Definitions
- 20: Payment Rules
- 20.1.1: General
- 20.1.2: Jurisdiction
- 20.1.3: Services Provided
- 20.1.4: Components of the Ambulance Fee Schedule
- 20.1.5: ZIP Code Determines Fee Schedule Amounts
- 20.1.5.1: CMS Supplied National ZIP Code File and National Ambulance Fee Schedule File
- 20.1.6: Contractor Determination of Fee Schedule Amounts
- 20.2: Payment for Mileage Charges
- 20.3: Air Ambulance

- 20.4: Ambulance Inflation Factor (AIF)
- 20.5: Documentation Requirements

Fact Sheet – "Ambulance Fee Schedule"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243658.html
Learn about Ambulance Fee Schedule (FS) background, the Medicare Part B ambulance transport benefit, ambulance providers and suppliers, the Advance Beneficiary Notice of Noncoverage, and payments and updates to the Ambulance FS.

PROVIDERS ONLY

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following sections regarding Medical Review (MR) of air ambulance services:

- 6.4.1: "Reasonable" Requests
- 6.4.2: Emergency Medical Services (EMS) Protocols
- 6.4.3: Prohibited Air Ambulance Relationships
- 6.4.4: Reasonable and Necessary Services
- 6.4.5: Definition of Rural Air Ambulance Services

More Resources: Refer to the Critical Access Hospital (CAH), Hospital, or Skilled Nursing Facility (SNF) pathways for additional information on ambulance services provided for beneficiaries who are inpatients in one of those facilities.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections outlining the Financial Liability Protection (FLP) provisions that protect beneficiary and health care providers and suppliers under certain circumstances for unexpected liability for charges associated with ambulance claims that Medicare does not pay:

- 20.2: Denials for Which the Limitation On Liability Provision Does Not Apply
- 20.2.2: Technical Denials
- 40.3.7.2: Other Situations

Webpage – Transmittals

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
This webpage allows you to select the Transmittal year, then filter on Ambulance Services for transmittals related to the ambulance provider community.

Webpage – Ambulance Fee Schedule – AFS Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/AFS-Regulations-and-Notices.html
This webpage provides a list of the Federal regulations and notices for the AFS.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term ambulance for related questions and answers. For example, FAQ1811 which explains when an Advance Beneficiary Notice (ABN) may be needed and issued to a beneficiary who is not in a state of emergency.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about ambulance services. Use the search feature on the home page to review these.

Electronic Mailing List – Ambulance

https://list.nih.gov/cgi-bin/wa.exe?A0=ambulance-l
The Ambulance electronic mailing list is administered by CMS and is used to distribute information and policies related to the Medicare AFS and Fee-For-Service (FFS) ambulance suppliers.

Beneficiary Booklet – "Medicare Coverage of Ambulance Services"

https://www.medicare.gov/Pubs/pdf/11021-Medicare-Ambulance-Services.pdf
This booklet explains ambulance coverage under Original Medicare. It provides information on coverage, payment, and rights and protection issues.

AMBULATORY SURGICAL CENTER

INTRODUCTION

This curriculum is designed as a pathway to Ambulatory Surgical Center Medicare resources.

DEFINITION: AMBULATORY SURGICAL CENTER (ASC)

An Ambulatory Surgical Center is a distinct entity that is certified as meeting the requirements for an ASC and enters into an agreement with the Centers for Medicare & Medicaid Services (CMS) exclusively for the purpose of furnishing outpatient surgical services to beneficiaries.

An ASC operates solely for purposes of providing surgical services to beneficiaries not requiring hospitalization and whose expected stay in the ASC does not exceed 24 hours. An ASC can be a fixed location or mobile in nature.

An ASC is either independent (that is, not a part of a provider of services or any other facility), or operated by a hospital (meaning, under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, a facility elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise. If the hospital-based surgical center is certified as an ASC, it is considered an ASC and is subject to rules for an ASC. If a hospital-based surgical center is not certified as an ASC, it continues under the program as part of the hospital.

More Resources: Refer to the Hospital pathway (outpatient section) for additional information regarding ambulatory surgical services provided to Medicare beneficiaries.

Webpage – Ambulatory Surgical Centers (ASC) Center

https://www.cms.gov/Center/Provider-Type/Ambulatory-Surgical-Centers-ASC-Center.html
The ASC Center contains helpful links to billing/payment, coverage, CMS manuals and transmittals, policies/regulations, contacts, and educational resources for an ASC.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," contains the following sections with information specific to an ASC:

- 15.4.2.1: Ambulatory Surgical Centers (ASCs)
- 15.5.2.1: Licenses and Certifications
- 15.5.4.2: Section 4 of the Form CMS-855B
- 15.5.20: Processing Form CMS-855R Applications
- 15.7.6: Special Processing Guidelines for Form CMS-855A, Form CMS-855B, Form CMS-855I and Form CMS-855R Applications

- 15.7.7.2.1: Processing Tie-In Notices/Approval Letters
- 15.7.8: Special Processing Guidelines for Independent CLIA Labs, Ambulatory Surgical Centers and Portable X-ray Suppliers
- 15.7.8.2: Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) -Initial Enrollment
- 15.7.8.3: Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Changes of Ownership (CHOWs)
- 15.7.8.4: Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO
- 15.9.1: Non-Certified Suppliers and Individual Practitioners
- 15.10.2: Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers
- 15.10.3: Voluntary Terminations

Form – Health Insurance Benefits Agreement – Ambulatory Surgical Center Form CMS-370

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS370.pdf
An ASC signs this supplier agreement for the purpose of establishing eligibility for payment.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Survey & Certification – Certification & Compliance – Ambulatory Surgery Centers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html
This webpage provides basic information about being certified as a Medicare ASC and includes links to applicable laws, regulations, and compliance information.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Ambulatory Surgical Centers (ASCs)

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/ASC.html
CMS develops CoPs and CfCs, which are minimum health and safety standards that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid Programs. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called deeming) meet or exceed the Medicare standards set forth in the CoPs/CfCs.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Ambulatory Surgery Centers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/ASCs.html
This webpage explains that survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of survey findings.

The ASC survey is conducted in accordance with the appropriate protocols and substantive requirements in the statute and regulations to determine whether a citation of non-compliance is appropriate. Deficiencies are based on a violation of the statute or regulations, which, in turn, is to be based on observations of the ASC's performance or practices.

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," includes Section 1018C, "Deemed Providers/Suppliers (Excluding CLIA Laboratories)," which explains that a health care entity must satisfy all applicable Federal requirements in order to enter into a provider or supplier agreement with the Medicare Program. Generally, the prospective provider or supplier demonstrates compliance with health and safety standards when it is certified by a Survey Agency (SA) as being in compliance and recommended to the RO for approval.

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," describes the steps a facility must go through to be certified as meeting the requirements for an ASC. Section 2210, "ASCs – Citations and Description," contains information regarding the sharing of space between an ASC and another provider.

IOM – "State Operations Manual," Pub. 100-07, Appendix L

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf
Appendix L, "Guidance for Surveyors: Ambulatory Surgical Centers," contains detailed protocols for the survey and certification process performed by either a State Agency (SA) or CMS surveyor.

Form – Ambulatory Surgical Center Request for Initial Certification or Update of Certification Information in the Medicare Program

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS377.pdf
ASC submission of this form initiates the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the SA.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02 Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," Section 260, "Ambulatory Surgical Center Services," explains that facility services furnished by an ASC in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and change requests.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf
Chapter 14, "Ambulatory Surgical Centers," contains the following important sections about coverage:

- 10: General
- 10.1: Definition of Ambulatory Surgical Center (ASC)
- 10.2: Ambulatory Surgical Center Services on ASC List
- 10.3: Services Furnished in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services
- 10.4: Coverage of Services in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services

BILLING

Webpage – Ambulatory Surgical Center (ASC) Payment

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html
This webpage provides links to information regarding ASC value-based purchasing, CMS recognized P-C IOLS and A-C IOLs, laser-assisted cataract surgery and CMS rulings.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
These code pair edits are applied to claims submitted by physicians, non-physician practitioners, and ASCs (provided the code is listed as one of the Medicare-approved ASC procedures).

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections relevant to ASC billing:

- 260: Ambulatory Surgical Center Services
- 260.1: Definition of Ambulatory Surgical Center (ASC)
- 260.2: Ambulatory Surgical Center Services
- 260.3: Services Furnished in ASCs Which are Not ASC Facility Services
- 260.4: Coverage of Services in ASCs, Which are Not ASC Services
- 260.5: List of Covered Ambulatory Surgical Center Procedures
- 260.5.1: Nature and Applicability of ASC List
- 260.5.2: Nomenclature and Organization of the List
- 260.5.3: Rebundling of CPT Codes

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following information regarding ASCs:

- 10: Jurisdiction for Claims
- 10.1: Carrier Jurisdiction of Requests for Payment
- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.12.1: Annual Open Participation Enrollment Process

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf
Chapter 14, "Ambulatory Surgical Centers," includes the following sections relevant to ASC billing:

- 20: List of Covered Ambulatory Surgical Center Procedures
- 20.1: Nature and Applicability of ASC List
- 20.2: Types of Services Included on the List
- 20.3: Rebundling of CPT Codes
- 50: ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500
- 70: Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

CLAIMS PROCESSING AND PAYMENT

Webpage – Ambulatory Surgical Center Payment – Program Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASCtransmittals.html
This webpage provides instructions and a link for searching the Program Transmittals List for transmittals affecting the ASC provider community.

Webpage – Ambulatory Surgical Center (ASC) Payment – New Technology Intraocular Lenses (NTIOLs)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/NTIOLs.html
This webpage includes a list of CMS-approved NTIOLs.

Webpage – Ambulatory Surgical Center (ASC) Payment – ASC Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html
This webpage is a central resource for the Federal regulations and notices for ASCs. From this webpage, providers can download the current calendar year's changes to the ASC payment system, as well as lists of codes for procedures which may be performed in an ASC under the Medicare Program, including the ASC payment group assigned to each procedure code.

Webpage – Ambulatory Surgical Center Payment

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html
This webpage provides information on ASC transmittals, ASC payment resources such as New Technology Intraocular Lenses (NTIOLs) and ASC regulations and notices.

Webpage – Ambulatory Surgical Center (ASC) Payment – ASC Payment Rates Archive Page

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/archive.html
This webpage contains past lists of codes for procedures performed in an ASC under the Medicare Program, as well as the ASC payment group assigned to each procedure code. The payment rates are archived by year in compressed or zipped files.

Webpage – Limited Data Set (LDS) Files

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/index.html
From this webpage, providers can download a file containing data for ASC services billed in the previous year, including services that were added under the revised ASC payment system. The ASC LDS file will be available twice a year, once for the Notice of Proposed Rule Making (NPRM) in late spring/early summer, and again within a month of publication of the Outpatient Prospective Payment System (OPPS) final rule in the Federal Register.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf
Chapter 14, "Ambulatory Surgical Centers," includes the following claims processing/payment sections:

- 30: Rate-Setting Policies
- 30.1: Where to Obtain Current Rates and Lists of Covered Services
- 40: Payment for Ambulatory Surgery
- 40.1: Payment to Ambulatory Surgical Centers for Non-ASC Services
- 40.2: Wage Adjustment of Base Payment Rates
- 40.3: Payment for Intraocular Lens (IOL)
- 40.4: Payment for Terminated Procedures
- 40.5: Payment for Multiple Procedures
- 40.6: Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

- 40.7: Offset for Payment for Pass-Through Devices Beginning January 1, 2008
- 40.8: Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008
- 40.9: Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)
- 40.10: Removal of Device Portion from Certain Discounted Device-Intensive Ambulatory Surgical Center (ASC) Procedures Prior to the Administration of Anesthesia
- 50: ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500
- 60.1: Applicable Messages for NTIOLs
- 60.2: Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008
- 60.3: Applicable ASC Messages for Certain Payment Indicators Effective for Services on or after January 1, 2009
- 70: Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," instructs providers in how to complete the Form CMS-1500 or its electronic equivalent, which is the basic form prescribed by CMS for the Medicare and Medicaid Programs for claims from physicians and suppliers. The following sections of the chapter have specific instructions for an ASC:

- 10.4: Items 14-33 – Provider of Service or Supplier Information
- 10.7: Type of Service (TOS)

Fact Sheet – "Ambulatory Surgical Center Fee Schedule"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243656.html
Learn about definition of an Ambulatory Surgical Center (ASC); ASC payment and payment rates; updates to the ASC Fee Schedule; and ASC Quality Reporting Program.

QUALITY

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)," includes several references to ASCs in regards to Medicare Advantage Plans including Quality Improvement Organization (QIO) expedited review.

Webpage – Health Care Consumer Initiatives – Ambulatory Surgical Centers

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareConInit/ASC.html
This webpage demonstrates CMS' commitment to making cost and quality data available to all Americans. It lists files containing charge and Medicare payment data for procedures commonly performed in ASCs and other provider sites. The data is updated annually and listed in zipped files by year.

Webpage – Survey & Certification – Certification & Compliance – Ambulatory Surgery Centers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html
Funds from the American Recovery and Reinvestment Act (Recovery Act) will be provided to States for the execution and implementation of Healthcare-Associated Infection (HAI) reduction strategies. Of the total $50 million appropriated to reduce HAIs, $10 million is provided for SAs to improve the survey process for Medicare-participating ASCs. The Downloads and Related Links on this webpage contain more information on the initiative.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Electronic Mailing List – ASC

https://list.nih.gov/cgi-bin/wa.exe?A0=ASC-L
The ASC electronic mailing list is administered by CMS, which emails subscribers information regarding policy, publications, coding, payment, and educational material.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the terms ASC and Ambulatory Surgical Center for related questions and answers. For example, FAQ2305 which addresses what procedures and services are payable when performed in the Ambulatory Surgical Center (ASC) setting under the revised ASC payment system.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about ASCs. Use the search feature on the home page of this website to review these.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

INTRODUCTION

This curriculum is designed as a pathway to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Medicare resources.

DEFINITION: DURABLE MEDICAL EQUIPMENT (DME) is equipment which:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

PROSTHETICS AND ORTHOTICS are devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

SUPPLIES are those that are necessary for the effective use of durable medical equipment including those drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment.

Webpage – Durable Medical Equipment (DME) Center

https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html
The DME Center contains helpful links to billing/payment, competitive bidding*, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations, enrollment/participation, coding, Medicare Secondary Payer, fraud & abuse, contacts (including Medicare Contractor websites), and educational resources for DMEPOS suppliers.

The DME Center webpage also contains links to the DMEPOS Supplier Manuals published by the individual Medicare Contractors. These manuals contain an overview of important and useful information for DMEPOS suppliers regarding the Medicare Program. It is the first resource that you should use for Medicare billing questions. The supplier manuals are updated quarterly.

*Detailed information on the DMEPOS Competitive Bidding Program is available later in this pathway.

ENROLLMENT

Website – National Supplier Clearinghouse

http://www.palmettogba.com/nsc
The National Supplier Clearinghouse (NSC) processes enrollment applications submitted by DMEPOS suppliers.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections pertinent to DMEPOS enrollment:

- 15.9.3: Approval of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- 15.19.1: Application Fees
- 15.19.2.3: Changes of Information and Ownership
- 15.21: Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions
- 15.21.1: DMEPOS Supplier Accreditation
- 15.21.2: Enrolling Indian Health Service (IHS) Facilities as DMEPOS Suppliers
- 15.21.4: Development and Use of Fraud Level Indicators

Webpage – Medicare Provider-Supplier Enrollment

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html
CMS offers a provider/supplier enrollment page with information about the enrollment process. From this page, DMEPOS suppliers can access links to information about the DMEPOS Surety Bond, DMEPOS Accreditation, and DMEPOS Supplier Standards.

Form – Medicare Enrollment Application – DMEPOS Suppliers Form CMS-855S

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855s.pdf
If a supplier does not enroll using the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment system, the paper enrollment application for DMEPOS Supplier (Form CMS-855S) is completed and mailed to the NSC.

Fact Sheet – "PECOS for DMEPOS Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243483.html
Learn about Medicare enrollment application submission options; as well as individual and organizational DMEPOS suppliers.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections about DMEPOS accreditation:
- 15.21.1: DMEPOS Supplier Accreditation
- 15.21.7: Surety Bonds

Webpage – Medicare Provider-Supplier Enrollment – DMEPOS Accreditation

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSAccreditation.html
This webpage provides information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and guidance. This webpage includes links to enrollment applications, surety bonds, provider enrollment regulations, revalidations, and compliance information. This page also includes information on Advanced Diagnostic Imaging Accreditation.

Webpage – Medicare Provider-Supplier Enrollment – DMEPOS Enrollment

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSEnrollment.html
This webpage provides a link to the electronic Code of Federal Regulations (e-CFR) which provides a full version of the DMEPOS Supplier Standards every Medicare DMEPOS supplier must meet in order to obtain and retain billing privileges. This webpage alerts certain DMEPOS suppliers that they need to obtain a $50,000 surety bond for each National Provider Identifier (NPI) as a prerequisite for enrolling and maintaining enrollment in the Medicare Program.

Webpage – National Supplier Clearinghouse Licensure Information

http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Standards%20Compliance~Licensure%20Information~7GLS4M6340
The NSC offers a supplier licensure database to help DMEPOS suppliers determine the licensure requirements needed for Medicare enrollment. The database is interactive, including licensure verification and hyperlinks to additional information. The search tool is arranged by product specialty.

Booklet – "DMEPOS Quality Standards"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN905709.html
Learn about Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards for suppliers, accreditation organizations, business services requirements and product-specific services requirements.

Fact Sheet – "DMEPOS Accreditation"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246764.html
This fact sheet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes information so suppliers can meet DMEPOS Quality Standards established by the Centers for Medicare & Medicaid Services (CMS) and become accredited by a CMS-approved independent national Accreditation Organization (AO). There is also information on the type of providers who are exempt.

Presentation – DMEPOS Accreditation 101

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/DMEPOSAccreditationPresentation.pdf
This presentation provides background and a basic introduction to the DME accreditation process.

Presentation – Compliance With The DMEPOS Quality Standards: What You Need To Know

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DMEPOSQualityStandardsPresentation.pdf
This presentation outlines the DMEPOS accreditation requirements as well as the DMEPOS quality standards.

Document – "Medicare New Deemed Accreditation Organizations for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/DeemedAccreditationOrganizationsCMB.pdf
This document lists the 10 AOs and their approved categories. Contact information for each AO is included so suppliers can contact the AOs directly for accreditation information.

Document – "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/DMEPOSAccreditationStandardsCMB.pdf
This document lists the quality standards suppliers must comply with including business services requirements, product–specific requirements, and the appendices.

MLN Matters® Article – SE1233 "Clarification of the Quality Standards and Accreditation Requirements for Ultra Lightweight Manual Wheelchairs"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1233.pdf

This Special Edition MLN Matters® article explains that effective for claims with dates of service on or after March 1, 2013, suppliers who furnish K0005 wheelchairs to Medicare beneficiaries and who are not in compliance with DMEPOS Quality Standards and Accreditation Requirements must come into compliance with these requirements or they will be required to stop furnishing these items to Medicare beneficiaries until these requirements are met.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes the following sections pertinent to DMEPOS coverage:

- 20: When Part B Expenses Are Incurred
- 40.18: Physicians or Practitioners Who Choose to Opt Out of Medicare
- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 110: Durable Medical Equipment – General
- 110.1: Definition of Durable Medical Equipment
- 110.2: Repairs, Maintenance, Replacement, and Delivery
- 110.3: Coverage of Supplies and Accessories
- 110.4: Miscellaneous Issues Included in the Coverage of Equipment
- 110.5: Incurred Expense Dates for Durable Medical Equipment
- 110.6: Determining Months for Which Periodic Payments May Be Made for Equipment Used in an Institution
- 110.7: No Payment for Purchased Equipment Delivered Outside the United States or Before Beneficiary's Coverage Began
- 120: Prosthetic Devices
- 130: Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes
- 140: Therapeutic Shoes for Individuals with Diabetes

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes reference to DME in a specific NCD. There might be other NCDs of interest in these manuals. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include DMEPOS Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 50.1: Speech Generating Devices

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 240.2: Home Use of Oxygen
- 280.1: Durable Medical Equipment Reference List (Effective May 5, 2005)
- 280.3: Mobility Assistive Equipment (MAE) (Effective May 5, 2005)

- 280.13: Transcutaneous Electrical Nerve Stimulators (TENS)
- 280.15: INDEPENDENCE iBOT 400 Mobility System (Effective July 27, 2006)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Section 10.2, "Coverage Table for DME Claims," contains a coverage chart showing payment that may be made for expenses incurred by a beneficiary for the rental or purchase of DME for use in a beneficiaries' home and the conditions that must be met for coverage.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
Chapter 5, "Items and Services Having Special DME Review Considerations," includes the following sections:

- 5.1: Home Use of DME
- 5.2.1: Physician Orders
- 5.2.2: Verbal and Preliminary Written Orders
- 5.2.3: Detailed Written Orders
- 5.2.3.1: Written Orders Prior to Delivery
- 5.2.4: Requirement of New Orders
- 5.2.5: Billing for Refills of DMEPOS Items Provided on a Recurring Basis
- 5.2.6: Refills of DMEPOS Items Provided on a Recurring Basis
- 5.3: Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs)
- 5.3.1: Completing a CMN or DIF
- 5.3.2: Cover Letters for CMNs
- 5.4: DME MACs and DME PSC's Authority to Initiate an Overpayment or CMP When Invalid CMNs Are Identified
- 5.5: Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and CMNs
- 5.6: Physician Assistant Rules Concerning Orders and CMNs
- 5.7: Documentation in the Patient's Medical Record
- 5.8: Supplier Documentation
- 5.8.1: Suppliers Documentation for DMEPOS Repair Claims
- 5.9: Evidence of Medical Necessity
- 5.9.1: Evidence of Medical Necessity for the Oxygen CMN
- 5.9.2: Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims
- 5.10: Period of Medical Necessity – Home Dialysis Equipment
- 5.11: Safeguards in Making Monthly Payments
- 5.12: Pick-up Slips
- 5.13: Incurred Expenses for DME and Orthotic and Prosthetic Devices
- 5.15: Definition of Customized DME
- 5.16: Advance Determination of Medical Coverage (ADMC) of Customized DME
- 5.16.1: Items Eligible for ADMC
- 5.16.2: Instructions for Submitting ADMC Requests
- 5.16.3: Instructions for Processing ADMC Requests
- 5.16.4: Affirmative ADMC Decisions
- 5.16.5: Negative ADMC Decisions
- 5.17: DME MAC Tracking

Podcast – "Power Mobility Device Face-to-Face Examination Checklist"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/CMS1249043.html
This podcast is designed to provide education on the documentation requirements for the face-to-face examination that occurs before ordering a power mobility device for Medicare beneficiaries. It includes information from MLN Matters® Article SE1112, which includes a checklist to use during this examination.

Web-Based Training – "Certificate of Medical Necessity (CMN)"

https://learner.mlnlms.com/
This WBT course is designed to provide education on the Certificate of Medical Necessity (CMN). It includes information on submission and maintenance of documentation required for verification of a CMN.

MLN Matters® Article – SE1305 Revised "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
This Special Edition MLN Matters® article explains that under Phase 1, Medicare alerted the billing supplier that the identification of the ordering/referring supplier is missing, incomplete, or invalid, or that the ordering/referring supplier is not eligible to order or refer. Under Phase 2, Medicare will deny claims for services or supplies that require an ordering/referring supplier to be identified and that supplier is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Section 30.6.15.4, "Power Mobility Devices (PMDs) (Code G0372)," explains physician billing and coding for exams where the physician/Non-Physician Practitioner (NPP) orders a PMD.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20 includes the following sections related to DMEPOS billing:

- 10: Where to Bill DMEPOS and PEN Items and Services
- 10.1.1: Durable Medical Equipment (DME)
- 10.1.2: Prosthetic Devices – Coverage Definition
- 10.1.3: Prosthetics and Orthotics (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) – Coverage Definition
- 10.1.4.1: Prosthetic Devices
- 10.1.4.2: Prosthetic and Orthotic Devices (P&O)
- 10.2: Coverage Table for DME Claims
- 10.3: Beneficiaries Previously Enrolled in Managed Care Who Return to Traditional Fee for Service (FFS)
- 100: General Documentation Requirements
- 100.1: Written Order Prior to Delivery
- 100.1.1: Written Order Prior to Delivery – HHAs
- 100.2: Certificates of Medical Necessity (CMN)

- 100.2.1: Completion of Certificate of Medical Necessity Forms
- 100.2.2: Evidence of Medical Necessity for Parenteral and Enteral Nutrition (PEN) Therapy
- 100.2.2.1: Scheduling and Documenting Certifications and Recertifications of Medical Necessity for PEN
- 100.2.2.2: Completion of the Elements of PEN CMN
- 100.2.2.3: DME MAC Review of Initial PEN Certifications
- 100.2.3: Evidence of Medical Necessity for Oxygen
- 100.2.3.1: Scheduling and Documenting Recertifications of Medical Necessity for Oxygen
- 100.2.3.2: HHA Recertification for Home Oxygen Therapy
- 100.2.3.3: DME MAC Review of Oxygen Certifications
- 100.3: Limitations on DME MAC Collection of Information
- 100.4: Reporting the Ordering/Referring NPI on Claims for DMEPOS Items Dispensed Without a Physician's Order
- 110: General Billing Requirements – for DME, Prosthetics, Orthotic Devices, and Supplies
- 110.1: Billing/Claim Formats
- 110.1.1: Requirements for Implementing the NCPDP Standard
- 110.1.2: Certificate of Medical Necessity (CMN)
- 110.1.3: NCPDP Companion Document
- 110.2: Application of DMEPOS Fee Schedule
- 110.3: Pre-Discharge Delivery of DMEPOS for Fitting and Training
- 110.3.1: Conditions That Must Be Met
- 110.3.2: Date of Service for Pre-Discharge Delivery of DMEPOS
- 110.3.3: Facility Responsibilities During the Transition Period
- 110.4: Frequency of Claims for Repetitive Services (All Providers and Suppliers)
- 110.5: DME MACs Only – Appeals of Duplicate Claims
- 120: DME MACs – Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades
- 120.1: Providing Upgrades of DMEPOS Without Any Extra Charge
- 130: Billing for Durable Medical Equipment (DME) and Orthotic/Prosthetic Devices
- 130.1: Provider Billing for Prosthetic and Orthotic Devices
- 130.2: Billing for Inexpensive or Other Routinely Purchased DME
- 130.3: Billing for Items Requiring Frequent and Substantial Servicing
- 130.4: Billing for Certain Customized Items
- 130.5: Billing for Capped Rental Items (Other Items of DME)
- 130.6: Billing for Oxygen and Oxygen Equipment
- 130.6.1: Oxygen Equipment and Contents Billing Chart
- 130.7: Billing for Maintenance and Servicing (Providers and Suppliers)
- 130.8: Installment Payments
- 130.9: Showing Whether Rented or Purchased
- 140.1: Billing for Supplies and Drugs Related to the Effective Use of DME
- 140.2: Billing for HHA Medical Supplies
- 140.3: Billing DME MAC for Home Dialysis Supplies and Equipment
- 150: Institutional Provider Reporting of Service Units for DME and Supplies
- 160: Billing for Total Parenteral Nutrition and Enteral Nutrition
- 170: Billing for Splints and Casts
- 211.1: General Information

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," provides instructions on completing Health Insurance Claim Form CMS-1500. Section 10.4 covers Item 17 in which the name of the referring or ordering physician is required for DME claims. Section 10.4 also covers Item 32 where, for durable medical equipment, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections which contain information about ABN standards for DMEPOS upgrades, conditions under which ABNs may be grounds for a claim being denied, and guidelines for refunds:

- 50.8: ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- 50.9: ABNs for Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts
- 50.10: ABNs for Claims Denied Under §1834(j)(1) of the Act (Supplier Did Not Meet Supplier Number Requirements)
- 50.11.1: Situations In Which Advance Coverage Determinations Are Mandatory
- 50.11.2: Situations In Which Advance Coverage Determinations Are Optional
- 50.13: Collection of Funds and Refunds

More Resources: Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the Medicare Contractor.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the Medicare Contractor.

Booklet – "Medicare Advance Beneficiary Notices"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1236637.html
Learn about types of Advance Beneficiary Notices (ABNs), prohibitions and frequency limits, completing the ABN, collecting payment from the beneficiary, financial liability and the ABN, and claim reporting modifiers.

Fact Sheet – "Continuous and Bi-level Positive Airway Pressure (CPAP/BPAP) Devices: Complying with Documentation & Coverage Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1242869.html
This fact sheet is designed to provide education on common Comprehensive Error Rate Testing Program errors related to PAP devices. It includes a checklist of documentation requirements and coding information necessary to support a claim submitted to Medicare for PAPs.

Fact Sheet – "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243510.html
This fact sheet is designed to provide education on Medicare coverage and billing requirements for power mobility devices (PMDs). It includes information concerning basic coverage criteria and documentation requirements as well as, detailed coverage guidelines for the specific type of PMD provided.

Fact Sheet – "Provider Compliance Tips for Diabetic Test Strips"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909185.html
This fact sheet is designed to provide education on Diabetic Test Strips. It includes helpful tips on how to prevent claim denials as well as documentation needed to submit a claim for Diabetic Testing Supplies.

Podcast – "Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/CMS1252820.html
This podcast is designed to provide education on the documentation and coverage requirements needed to submit Medicare claims for Positive Airway Pressure (PAP) devices. It includes information from the Medicare Learning Network® fact sheet titled "Positive Airway Pressure (PAP) Devices – Complying with Documentation & Coverage Requirements," which describes common Comprehensive Error Rate Testing Program errors related to PAP devices.

MLN Matters® Article – MM7888 "New Healthcare Common Procedure Coding System (HCPCS) Code for External Ventricular Assist Devices or Any Ventricular Assist Device (VAD) For Which Payment Was Not Made Under Medicare Part A"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7888.pdf
This MLN Matters® article instructs Medicare Contractors to implement a new HCPCS code in order to process claims for accessories and supplies for external VADs or any VAD for which payment was not made under Medicare Part A.

MLN Matters® Article – MM8172 Revised "Revision to CWF and VMS: Reject or Informational Unsolicited Response (IUR) Edit for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provided During an Inpatient Stay"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8172.pdf
This MLN Matters® article alerts hospitals and DMEPOS suppliers that claims for DMEPOS items to beneficiaries received in a covered inpatient stay are considered an overpayment and may be rejected or line item denied. DMEPOS suppliers are encouraged to review this article in order to avoid potential overpayment situations.

MLN Matters® Article – MM8525 Revised "National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8525.pdf
This article is based on Change Request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for certain indications.

Competitive Bidding

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 36

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c36.pdf
Chapter 36, "Competitive Bidding," is a comprehensive resource for information about the DMEPOS Competitive Bidding process and includes the following sections:

- 10: Background
- 10.1: Competitive Bidding Implementation Contractor (CBIC)
- 10.2: Definitions
- 20: DMEPOS Competitive Bidding Process
- 20.1: Items Subject to Competitive Bidding
- 20.2: Competitive Bidding Areas (CBAs)
- 20.3: No Administrative or Judicial Review
- 20.4: Eligibility Requirements to Submit a Bid
- 20.5: Becoming a Contract Supplier
- 20.5.1: Small Suppliers and Networks
- 20.5.2: Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)
- 20.5.3: Home Health Agencies
- 20.5.3.1: Mail-Order Suppliers for Diabetic Supplies
- 20.5.4: Items Furnished on a Mail Order Basis
- 20.5.4.1: Mail-Order Suppliers for Diabetic Supplies
- 20.6: Noncontract Suppliers
- 20.6.1: Special Rules for Certain Rented Durable Medical Equipment (DME), Oxygen and Oxygen Equipment (Grandfathered Suppliers and Items)
- 20.6.1.1.1: Eligibility
- 20.6.1.1.2: Servicing Current Beneficiaries
- 20.6.1.1.3: Notification to Beneficiaries by Suppliers that Choose to Become Grandfathered Suppliers
- 20.6.1.1.4: Notification to Beneficiaries for Suppliers that Choose Not to Become Grandfathered Suppliers
- 20.6.2: New Period of Continuous Use
- 20.6.3: Picking Up Equipment
- 20.6.4: Transfer of Title for Oxygen Equipment and Capped Rental DME
- 20.6.5: Capped Rental DME Furnished Prior to January 1, 2006
- 20.7: Use of Advanced Beneficiary Notice (ABNs)
- 30.1: Compliance with Laws and Regulations
- 30.2: Requirement to Maintain Medicare Billing Privileges and Accreditation
- 30.3: Servicing the Entire Geographic Area of a CBA
- 30.4: Prescription for Particular Brand, Item, or Mode of Delivery
- 30.5: No Discrimination Against Beneficiaries
- 30.6: Quarterly Reports
- 30.7: Reporting Change of Ownership (CHOW)
- 30.8: Submission of Claims
- 30.9: Breach of Contract
- 30.10: Request for Reconsideration
- 40: Payment Rules
- 40.1: Single Payment Amount
- 40.2: Conditions for Payment
- 40.3: Payment for Grandfathered Items Furnished During the Initial Competitive Bidding Contract Period/Program
- 40.3.1.1: Inexpensive or Routinely Purchased Items
- 40.3.1.2: Items Requiring Frequent and Substantial Servicing
- 40.3.1.3: Oxygen and Oxygen Equipment
- 40.3.1.4: Other DME or Capped Rental Items
- 40.3.2: Payment for Grandfathered Items Furnished During Subsequent Competitive Bidding Contract Periods/Programs
- 40.3.3: Accessories and Supplies for Grandfathered Items
- 40.4: Payment for Rental of Inexpensive or Routinely Purchased DME
- 40.5: Payment for Oxygen and Oxygen Equipment
- 40.5.1: Change in Suppliers for Oxygen and Oxygen Equipment
- 40.6: Payment for Capped Rental DME Items

- 40.6.1: Change in Suppliers for Capped Rental DME Items
- 40.7: Payment for Purchased Equipment
- 40.8: Payment for Repair and Replacement of Beneficiary-Owned Equipment
- 40.9: Payment for Rental Enteral Nutrition Equipment
- 40.9.1: Maintenance and Servicing of Enteral Nutrition Equipment
- 40.10: Traveling Beneficiaries
- 40.10.1: Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items
- 50.1: Electronic Submission of Claims and Mandatory Assignment
- 50.2: New Modifiers for DMEPOS Competitive Bidding Billing
- 50.3: Billing for Items in Multiple Product Categories
- 50.4: Claims Jurisdiction and Billing Procedures for Traveling Beneficiaries
- 50.5: Claims for DMEPOS Items Furnished to a Beneficiary by a Skilled Nursing Facility (SNF) or Nursing Facility (NF)
- 50.6: Billing for Mail Order Items
- 50.7: Claims Submitted for Physicians/Practitioners Who Furnish Competitively Bid Items
- 50.8: Billing for Oxygen and Oxygen Equipment
- 50.9: Billing for Capped Rental DME Items
- 50.9.1: Certificates of Medical Necessity (CMN) and Capped Rental Billing
- 50.10: Claims Submitted for Hospitals Who Furnish Competitively Bid Items
- 50.11: Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan
- 50.12: Claims for Repairs and Replacements
- 50.13: Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap
- 50.14: Purchased Accessories & Supplies for Use With Grandfathered Equipment
- 50.15: Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge
- 50.16: Exception for Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," provides information regarding ABNs for items listed in a DMEPOS Competitive Bidding Program.

Webpage – DMEPOS Competitive Bidding – Home

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html
This webpage includes an overview of the DMEPOS Competitive Bidding Program as well links to the other competitive bidding-related webpages including contractor supplier lists, Federal regulations, notices, and manual instructions and educational resources.

Webpage – DMEPOS Competitive Bidding – Educational Resources

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Round-2-and-National-Mail-Order/Educational_Resources.html
The educational resources listed on this webpage are designed to increase national awareness and provider education on the DMEPOS Competitive Bidding Program for the Non-Contract Supplier and Referral Agent Community.

Webpage – Competitive Bidding Implementation Contractor

http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home
CMS has contracted with Palmetto GBA to administer the DMEPOS Competitive Bidding Program. Palmetto GBA is responsible for conducting certain functions including performing bid evaluations, selecting qualified suppliers, setting payments for all competitive bidding areas and overseeing an education program. Palmetto GBA also assists CMS and its contractors in monitoring the program's effectiveness, access, and quality.

Webpage – Partner with CMS – DMEPOS Toolkit

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html
Partnering with CMS is a key to helping people with Medicare maximize their benefits. Beyond extending the reach of these important benefits to people who need them, a partnership helps you leverage resources by fostering relationships with other CMS partners, keeps you informed, and provides you with expert training, educational materials and tools such as this toolkit.

Fact Sheet – "The DMEPOS Competitive Bidding Program Billing Procedures for Upgrades"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1242798.html
Learn about rules that apply when a beneficiary wants to obtain an upgrade; which DMEPOS suppliers can provide the item; how the item will be paid; beneficiary liability for upgraded items; and Advance Beneficiary Notice (ABN) requirements.

Fact Sheet – "The DMEPOS Competitive Bidding Program – A Better Way for Medicare to Pay for Medical Equipment"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243351.html
Learn about how the Competitive Bidding Program works; Competitive Bidding Program areas and product categories; and how the program benefits beneficiaries.

Fact Sheet – "The DMEPOS Competitive Bidding Program Enteral Nutrition"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243502.html
Learn about requirements for providing enteral nutrition therapy and rules for enteral nutrition payment.

Fact Sheet – "The DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243501.html
Learn about what are grandfathered suppliers; notifications requirements under the grandfathering provisions; and transitioning a beneficiary from a non-contract supplier to a contract supplier.

Fact Sheet – "The DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243495.html
Learn about an exception to regular program rules for walkers provided by hospitals that are not contract suppliers; requirements to meet the exception; and payment rules under this exception.

Fact Sheet – "The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1249020.html
Learn about the requirements related to providing mail-order diabetes supplies to beneficiaries; the beneficiary's options to purchase diabetes testing supplies; and the Anti-Switching Rule.

Fact Sheet – "The DMEPOS Competitive Bidding Program Non-Contract Supplier"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243505.html
Learn about specific program requirements for non-contract suppliers that furnish rented DME or oxygen and oxygen equipment; enteral nutrition and mail-order diabetes testing supplies; requirements for SNFs that are not contract suppliers; and program exceptions that apply to non-contract suppliers.

Fact Sheet – "The DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243496.html
Learn about one exception for physicians and treating practitioners enrolled as Medicare DMEPOS Suppliers; requirements to qualify for the exception; and payment rules under this exception.

Fact Sheet – "The DMEPOS Competitive Bidding Program Repairs and Replacements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1241991.html
Learn about rules for repair and replacement of beneficiary-owned equipment under the DMEPOS competitive bidding program and which items and services can be provided by contract versus non-contract suppliers.

Fact Sheet – "The DMEPOS Competitive Bidding Program Traveling Beneficiary"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243497.html
Learn about rules for Medicare beneficiaries who reside in or travel to areas impacted by the DMEPOS Competitive Bidding Program; how to properly bill Medicare for the item; and how Medicare will determine the payment amount.

Document – "DMEPOS Competitive Bidding Program- A Guide to Answer Consumer Questions"

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/DMEPOSCBPartnerGuidetoAnswerConsumerQuestions061510FINAL508.pdf
This document is appropriate for suppliers to use in answering beneficiary questions about the DMEPOS Competitive Bidding Program, and includes a chart for guiding beneficiaries who will require DMEPOS items while traveling.

MLN Matters® Article – MM8080 Revised "Durable Medical Equipment (DME) National Competitive Bidding (NCB): National Mail Order (NMO) Program Implementation for Diabetic Supplies"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8080.pdf
This MLN Matters® article reminds suppliers that, effective July 1, 2013, Medicare Part B payment for covered diabetic testing supplies delivered to a Medicare beneficiary' s home by any method is subject to the NMO Competitive Bidding Program. This program applies throughout the United States with the exception of the Northern Mariana Islands.

MLN Matters® Article – MM8525 Revised "National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8525.pdf
This article is based on Change Request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for certain indications.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," provides general instructions on billing and claims processing for DMEPOS, Parenteral and Enteral Nutrition (PEN), and supplies. Chapter 20 includes the following sections pertinent to claims processing and payment:

- 20: Calculation and Update of Payment Rates
- 20.1: Update Frequency
- 20.2: Locality
- 20.3: Elimination of "Kit" Codes and Pricing of Replacement Codes
- 20.4: Contents of Fee Schedule File
- 20.5: Online Pricing Files for DMEPOS
- 30: General Payment Rules
- 30.1: Inexpensive or Other Routinely Purchased DME
- 30.1.1: Used Equipment
- 30.1.1.2: Used Rental Equipment
- 30.1.2: Transcutaneous Electrical Nerve Stimulator (TENS)
- 30.2: Items Requiring Frequent and Substantial Servicing
- 30.2.1: Daily Payment for Continuous Passive Motion (CPM) Devices
- 30.3: Certain Customized Items
- 30.4: Other Prosthetic and Orthotic Devices
- 30.5: Capped Rental Items
- 30.5.1: Capped Rental Fee Variation by Month of Rental
- 30.5.2: Purchase Option for Capped Rental Items
- 30.5.3: Additional Purchase Option for Electric Wheelchairs
- 30.5.3.1: Exhibits
- 30.5.4: Payments for Capped Rental Items During a Period of Continuous Use
- 30.5.5: Payment for Power-Operated Vehicles that May Be Appropriately Used as Wheelchair
- 30.6: Oxygen and Oxygen Equipment
- 30.6.1: Adjustments to Monthly Oxygen Fee
- 30.6.2: Purchased Oxygen Equipment
- 30.6.3: Contents Only Fee
- 30.6.4: DMEPOS Clinical Trials and Demonstrations
- 30.7: Payment for Parenteral and Enteral Nutrition (PEN) Items and Services
- 30.7.1: Payment for Parenteral and Enteral Pumps
- 30.7.2: Payment for PEN Supply Kits
- 30.8: Payment for Home Dialysis Supplies and Equipment
- 30.8.1: DME MAC and A/B MAC (A) Determination of ESRD Method Selection
- 30.8.2: Installation and Delivery Charges for ESRD Equipment
- 30.8.3: Elimination of Method II Home Dialysis
- 30.9: Payment of DMEPOS Items Based on Modifiers
- 40.1: General
- 40.2: Maintenance and Service of Capped Rental Items
- 40.3: Maintenance and Service of PEN Pumps
- 50: Payment for Replacement of Equipment
- 50.1: Payment for Replacement of Capped Rental Items
- 50.2: A/B MAC (A) or (HHH) Format for Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule
- 50.3: Payment for Replacement of Parenteral and Enteral Pumps
- 50.4: Payment for Replacement of Oxygen Equipment in Bankruptcy Situations

- 60: Payment for Delivery and Service Charges for Durable Medical Equipment
- 80: Penalty Charges for Late Payment Not Included in Reasonable Charges or Fee Schedule Amounts
- 90: Payment for Additional Expenses for Deluxe Features
- 110: General Billing Requirements – for DME, Prosthetics, Orthotic Devices, and Supplies
- 110.1: Billing/Claim Formats
- 110.1.1: Requirements for Implementing the NCPDP Standard
- 110.1.2: Certificate of Medical Necessity (CMN)
- 110.1.3: NCPDP Companion Document
- 110.2: Application of DMEPOS Fee Schedule
- 110.5: DME MACs Only - Appeals of Duplicate Claims
- 120: DME MACs - Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades
- 120.1: Providing Upgrades of DMEPOS Without Any Extra Charge
- 190: Contractor Application of Fee Schedule and Determination of Payments and Patient Liability for DME Claims
- 200: Automatic Mailing/Delivery of DMEPOS
- 210: CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay
- 211.1: General Information
- 220: Appeals
- 230: DME MAC Systems

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," provides fee schedule information and coding guidance for DMEPOS, including the following sections:

- 30.3.4: Responsibility to Obtain and Implement Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedules
- 60: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- 60.1: Record Layout for DMEPOS Fee Schedule
- 60.2: Quarterly Update Schedule for DMEPOS Fee Schedule
- 60.3: Gap-filling DMEPOS Fees
- 60.3.1: Payment Concerns While Updating Codes
- 60.4: Process for Submitting Revisions to DMEPOS Fee Schedule to CMS
- 60.5: Rural ZIP Code Claim Record Layout for Medicare Contractors Processing Rural DMEPOS Fee Schedule Claims
- 80: Reasonable Charges as Basis for A/B MAC (B)/DME MAC Payments
- 80.1: Criteria for Determining Reasonable Charge
- 80.2: Updating Customary and Prevailing Charges
- 80.3: The Customary Charge
- 80.3.1: Calculating Customary Charge
- 80.3.1.1: Equity Adjustments in Customary Charge Screens
- 80.3.2: Customary Charge Profile
- 80.4: Prevailing Charge
- 80.4.1: Rounding of Reasonable Charge Calculation
- 80.5: Filling Gaps in A/B MAC (B) Reasonable Charge Screens
- 80.5.1: Use of Relative Value Scale and Conversion Factors for Reasonable Charge Gap-Filling
- 80.6: Inflation Indexed Charge (IIC) for Nonphysician Services
- 80.7: Determination of Comparable Circumstances
- 80.8: Applying Criteria for Reasonable Charge Determinations
- 80.8.1: Waiver of Deductible and Coinsurance
- 100: Competitive Bidding Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Single Payment Amounts
- 100.1: Record Layout for Competitive Bidding HCPCS Category File
- 100.2: Record Layout for Competitive Bidding Pricing File

- 100.3: Record Layout for Competitive Bidding ZIP Code File
- 100.4: Record Layout for Competitive Bidding Contract Supplier File
- 100.5: Adjustments to the Single Payment Amounts to Reflect Changes in HCPCS Codes

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
Chapter 5, "Items and Services Having Special DME Review Considerations," contains Section 5.4, "DME MACs and DME PSC's Authority to Initiate an Overpayment or CMP When Invalid CMNs Are Identified." When the Medicare Contractors, DME Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs) identify a claim for which a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF) is not valid, they may deny the claim and/or initiate overpayment action. If a Medicare Contractor, DME PSC, or ZPIC identifies a supplier that has a pattern of improperly completing the CMN or DIF, the Medicare Contractor or DME PSC or ZPIC may choose to initiate a potential CMP case against the supplier.

Webpage – DMEPOS Fee Schedule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html
See this page for the most recent DMEPOS Fee Schedule and corresponding background documents. A document named "DMEBACK" included in the zip file with the fee schedule contains explanations for how each type of DMEPOS is paid.

Fact Sheet – "Provider Compliance Tips for Enteral Nutrition Pumps"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909186.html
This fact sheet is designed to provide education on Enteral Nutrition Pumps. It includes helpful tips on how to prevent claim denials as well as documentation needed to submit a claim for Enteral Nutrition Pumps.

MLN Matters® Article – MM7498 Revised "Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): Allowing Contract or Non-contract Suppliers to Maintain and Service the Enteral Nutrition Equipment That They Provided in the 15th Continuous Month of Rental"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7498.pdf
This MLN Matters® article outlines the requirements for the maintenance and servicing of enteral nutrition equipment under the Medicare DMEPOS Competitive Bidding Program.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Review Contractor Directory – Interactive Map

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
The Review Contractor Directory - Interactive Map allows you access to state-specific CMS contractor contact information. The Provider Call Center Toll Free Number Directory can be found in the interactive map.

Webpage – DMEPOS Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Transmittals.html
This webpage shows the transmittals that are directed to the DMEPOS provider community, but the list may not include all instructions for which DMEPOS providers are responsible. (Program transmittals are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual.) The cover page (or transmittal page) summarizes the new material, specifying what is changed. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. DMEPOS items are considered DHS.

Webpage – Open Door Forums – Home Health, Hospice & Durable Medical Equipment Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME.html
The Home Health, Hospice & Durable Medical Equipment Open Door Forum (ODF) addresses the concerns of three unique health care areas within the Medicare & Medicaid Programs. Issues related to home health Prospective Payment System (PPS), the competitive bidding for DME, and the Medicare Hospice benefit are all topics the forum has covered. Many of the issues covered bridge concerns within all three settings, and the combination of the topics under one forum has been useful to many participants. CMS continues to hold Special ODFs when individual policy issues require special attention. Timely announcements and clarifications regarding important rulemaking, agency program initiatives, and other related areas are also included in the forums.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about DMEPOS and DMEPOS suppliers. Use the search feature on the home page of this website to review these.

Electronic Mailing List – DMEPOS-Suppliers

https://list.nih.gov/cgi-bin/wa.exe?A0=dmepos-suppliers-l
The DMEPOS-Suppliers electronic mailing list is administered by CMS, which emails subscribers information regarding DMEPOS publications, coding, payment, and educational material.

Document – "Telemarketing Frequently Asked Questions"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/DME_Telemarketing_FAQs.pdf
This document answers three commonly asked questions about telephone contact between DMEPOS suppliers and beneficiaries.

Fact Sheet – "DMEPOS Information for Pharmacies"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246766.html
Learn about requirements for pharmacies seeking consideration for exemption from the National Supplier Clearinghouse; pharmacy attestation information; and change of ownership.

FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC

INTRODUCTION

This curriculum is designed as a pathway to Federally Qualified Health Center and Rural Health Clinic Medicare resources.

Definition: Health Center

Section 330 of the Public Health Service Act (42 USCS § 254b) defines the term health center as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements.

Definition: Federally Qualified Health Center (FQHC)

Generally, in order to qualify as a FQHC, the facility must be receiving, or be eligible to receive, certain types of Federal grants (sometimes referred to as grant status) or must be an outpatient facility operated by an Indian tribal organization. FQHCs furnish preventive services. RHCs do not.

Definition: Rural Health Clinic (RHC)

RHCs are clinics that are located in areas that are designated both by the Bureau of the Census as rural and by the Secretary of the Department of Health and Human Services (HHS) as medically underserved. An RHC is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases. RHCs are surveyed by the State; FQHCs are not.

Webpage – Federally Qualified Health Centers (FQHC) Center

https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
The FQHCs Center contains helpful links to billing/payment, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations, contacts, and educational resources for FQHCs.

Webpage – Rural Health Clinics Center

https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
The RHCs Center contains helpful links to billing/payment, coverage, CMS manuals and transmittals, policies/regulations, contacts, and educational resources for RHCs.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01 Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 10.4.2, "Agreement with Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC)," which describes the duration and renewal procedures for the agreement between CMS and an FQHC or RHC.

IOM – "State Operations Manual," Pub. 100-07, Exhibits, Exhibit 177

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_177.pdf
Exhibit 177, "Attestation Statement For Federally Qualified Health Center," addresses the signed and dated attestation statement that must be submitted by FQHCs. This attestation serves as the Medicare FQHC benefit (or provider/supplier) agreement.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," contains the following sections with information pertinent to FQHC and RHC enrollment:

- 15.4.1.4: Federally Qualified Health Centers (FQHCs)
- 15.4.1.13: Rural Health Clinics (RHCs)
- 15.19.1: Application Fees
- 15.19.2.3: Changes of Information and Ownership

Form – Medicare Enrollment Application – Institutional Providers Form CMS-855A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
FQHCs and RHCs must complete the enrollment application for institutional providers either as a paper Form CMS-855A or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

Form – Reassignment of Medicare Benefits Form CMS-855R

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855r.pdf
This application must be completed when an individual practitioner is reassigning his/her benefits to an eligible entity, such as an FQHC or RHC. An eligible entity is a business organization that is eligible to receive reassigned benefits (for example, employer, facility, health care delivery system, or agent).

Form – Health Insurance Benefits Agreement Form CMS-1561A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1561a.pdf
This form is signed by RHCs for the purpose of establishing eligibility for Medicare payment.

Form – Request To Establish Eligibility To Participate In The Health Insurance For The Aged and Disabled Program To Provide Rural Health Clinic Services Form CMS-29

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS29.pdf
Each RHC site providing services and desiring to establish eligibility in the health insurance program should complete this form and return it to the State agency that is handling the certification process.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Rural Health Clinic/Federally Qualified Health Center

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/RHC_FQHC.html
This webpage provides information on and links to the Code of Federal Regulations (CFR) sections that establish CfCs and CoPs for RHCs, as well as the CfCs for FQHCs.

Webpage – Survey & Certification – Certification & Compliance – Rural Health Clinics

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RHCs.html
This webpage provides basic information about being certified as a Medicare and/or Medicaid RHC provider and includes links to applicable laws, regulations, and compliance information.

Webpage – Survey & Certification – General Information – Policy & Memos to States and Regions

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html
This webpage includes links to all CMS Survey and Certification memoranda, guidance, clarifications, and instructions to State Survey Agencies and CMS Regional Offices. Use the search feature on this page to find documents pertinent to FQHCs and RHCs.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Rural Health Clinics

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/RHC.html
This webpage provides links to survey protocols and interpretive guidelines established to provide guidance to personnel conducting surveys of RHCs.

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," includes the following sections with information specific to the survey and certification of FQHCs:

- 1014: Relationship of Survey Date to Date of Initial Medicare Approval
- 1016: Approval and Correction of Deficiencies

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections about the RO certification process for FQHCs and RHCs:

- 2240: RHCs – Citations and Description
- 2242A: General
- 2242A1: Location of Clinic
- 2242A2: Medical Direction
- 2242A3: Physician Assistant, Nurse Practitioner, and/or Certified Nurse Midwife Staff
- 2242B: Clinic Is Determined Ineligible
- 2242D: Identifying Clinic as Provider-Based
- 2242E: Compliance with Civil Rights Statutes
- 2242F: Laboratory Services Provided in RHCs
- 2244: Preparing for RHC Survey
- 2246: Clinic's Request to Provide Visiting Nurse Services
- 2248: Clinic's Request for Waiver of Staffing Requirements
- 2248A: Applying Waiver to Applicants
- 2248B: Applying Waiver to Participating RHCs
- 2248C: Documentation Demonstrating Efforts to Meet Staffing Requirements
- 2248D: Monitoring Waivers
- 2248E: Notification
- 2249: RO Notification of RHC Initial Certification Approval
- 2825A: Citations
- 2825B: Description
- 2826A: General

- 2826B: Information to Be Provided to Potential Applicants
- 2826C: Request to Participate
- 2826D: Processing Requests
- 2826E: RO Assigning Applicants an FQHC CMS Certification Number (CCN)
- 2826F: Effective Date
- 2826G: RO Completion of Forms
- 2826H: Complaint Investigations

IOM – "State Operations Manual," Pub. 100-07, Appendix G

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf
Appendix G, "Guidance to Surveyors: Rural Health Clinics," contains the following sections:

- 491.4: Condition of Coverage: Compliance With Federal, State, and Local Laws
- 491.5: Condition of Coverage: Location of Clinic
- 491.6: Condition of Coverage: Physical Plant and Environment
- 491.7: Condition of Coverage: Organizational Structure
- 491.8: Condition for Certification: Staffing and Staff Responsibilities
- 491.9: Condition of Coverage: Provision of Services
- 491.10: Condition of Coverage: Patient Health Records
- 491.11: Condition of Coverage: Program Evaluation
- Table A: Publications of the Bureau of the Census – Maps Displaying Urbanized Areas
- Table B: Contacts in the Bureau of the Census Regional Offices
- Table C: Cities With Boundaries Extending to Rural Populations

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02 Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Chapter 13, "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services," contains the following sections with information specific to FQHCs and RHCs:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 20: RHC and FQHC Location Requirements
- 20.1: Non-Urbanized Area Requirement for RHCs
- 20.2: Designated Shortage Area Requirement for RHCs
- 30.1: RHC Staffing Requirements
- 30.2: RHC Temporary Staffing Waivers
- 30.3: FQHC Staffing Requirements
- 40: RHC and FQHC Visits
- 40.1: Location
- 40.2: Hours of Operation
- 40.3: Multiple Visits on Same Day
- 40.4: Global Billing
- 40.5: 3-Day Payment Window
- 50.1: RHC Services
- 50.2: FQHC Services
- 50.3: Emergency Services
- 60: Non RHC/FQHC Services
- 60.1: Description of Non RHC/FQHC Services
- 70: RHC and FQHC Payment Rates, Exceptions, and Adjustments
- 70.1: RHCs Billing Under the AIR

- 70.2: RHC Per-Visit Payment Limit and Exceptions
- 70.3: FQHC PPS Payment Rate and Adjustments
- 70.4: Payment Codes for FQHCs
- 80: RHC and FQHC Cost Reports
- 80.1: RHC and FQHC Cost Report Requirements
- 80.2: RHC and FQHC Consolidated Cost Reports
- 80.3: RHC and FQHC Cost Report Forms
- 80.4: RHC Productivity Standards
- 90: RHC and FQHC Patient Charges, Coinsurance, Deductible, and Waivers
- 90.1: Charges and Waivers
- 90.2: Sliding Fee Scale
- 100: Commingling
- 110: Physician Services
- 110.1: Dental, Podiatry, Optometry, and Chiropractic Services
- 110.2: Treatment Plans or Home Care Plans
- 110.3: Graduate Medical Education
- 110.4: Transitional Care Management(TCM) Services
- 110.5: Chronic Care Management (CCM) Services
- 120: Services and Supplies Furnished Incident to Physician's Services
- 120.1: Provision of Incident to Services and Supplies
- 120.2: Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC
- 120.3: Payment for Incident to Services and Supplies
- 130: Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services
- 130.1: NP, PA, CNM Requirements
- 130.2: Physician Supervision
- 130.3: Payment to Physician Assistants
- 140: Services and Supplies Incident to NP, PA, and CMN Services
- 150: Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services
- 160: Services and Supplies Incident to CP and CSW Services
- 170: Mental Health Visits
- 180: Physical and Occupational Therapy
- 190.1: Description of Visiting Nursing Services
- 190.2: Requirements of Visiting Nursing Services
- 190.3: Home Health Agency Shortage Area
- 190.4: Authorization for Visiting Nursing Services
- 190.5: Treatment Plans
- 200: Telehealth Services
- 210: Hospice Services
- 210.1: Hospice Attending Practitioner
- 210.2: Provision of Services to Hospice Patients in a RHC or FQHC
- 220: Preventive Health Services
- 220.1: Preventive Health Services in RHCs
- 220.2: Copayment and Deductible for RHC Preventive Health Services
- 210.3: Preventive Health Services in FQHCs
- 210.4: Copayment for FQHC Preventive Health Services

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," provides an overview of billing requirements for Medicare providers and includes FQHC/RHC-specific information in the following sections:

- 10.2: FI Jurisdiction of Requests for Payment
- 20: Provider Assignment to FIs and MACs
- 40.1.2: Change of Ownership
- 60.4: Noncovered Charges on Outpatient Bills
- 80.3.2.2: Consistency Edits for Institutional Claims
- 130.1.3: Late Charges

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf

Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes the following sections with information about FQHC and RHC billing:

- 20.1: General
- 280: Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

Chapter 9, "Rural Health Clinics/Federally Qualified Health Centers," contains the following sections of information specific to FQHC and RHC billing:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 20: RHC and FQHC All-Inclusive Rate (AIR) Payment System
- 20.1: Per Visit Payment and Exceptions under the AIR
- 20.2: Payment Limit under the AIR
- 30: FQHC Prospective Payment System (PPS) Payment System
- 30.1: Per-Diem Payment and Exceptions under the PPS
- 30.2: Adjustments under the PPS
- 40.1: Part B Deductible
- 40.2: Part B Coinsurance
- 50: General Requirements for RHC and FQHC Claims
- 60: Billing and Payment Requirements for RHCs and FQHCs
- 60.1: Billing Guidelines for RHC and FQHC Claims under the AIR System
- 60.2: Billing for FQHC Claims Paid Under the PPS
- 60.3: Payments for FQHC PPS Claims
- 60.4: Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
- 60.5: PPS Payments to FQHCs under Contract with MA Plans
- 70: General Billing Requirements for Preventive Services
- 70.1: RHCs Billing Approved Preventive Services
- 70.2: FQHCs Billing Approved Preventive Services under the AIR
- 70.3: FQHCs Billing Approved Preventive Services under the PPS
- 70.4: Vaccines
- 70.5: Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)
- 70.6: Initial Preventive Physical Examination (IPPE)
- 80: Telehealth Services
- 90: Services Non-covered on RHC and FQHC Claims
- 100: Frequency of Billing and Same Day Billing

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," contains specific billing information for RHCs and FQHCs in Section 40.1.3, "Special Billing Instructions for RHCs and FQHCs."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," contains special instructions for FQHCs and RHCs regarding billing of lab services in the following sections:

- 10: Background
- 30.1: Mandatory Assignment for Laboratory Tests
- 30.1.1: Rural Health Clinics
- 40.5: Rural Health Clinic (RHC) Billing
- 50.3.2: Hospital Laboratory Services Furnished to Nonhospital Patients

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," contains billing information for FQHCs/RHCs in the following sections:

- 10.2: Billing Requirements
- 10.2.2: Bills Submitted to FIs/AB MACs
- 10.2.2.2: Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)
- 10.3.2: Claims Submitted to A/B MACs (A) for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations
- 20.4: Billing Requirements – FI/A/B MAC Claims
- 20.4.1.1: RHC/FQHC Claims With Dates of Service Prior to January 1, 2002
- 20.4.1.2: RHC/FQHC Claims With Dates of Service on or After January 1, 2002
- 30.5: Screening Pap Smears: Healthcare Common Procedure Coding System (HCPCS) Codes for Billing
- 40.6: Revenue Code and HCPCS Codes for Billing
- 70.1.1.2: Special Billing Instructions for RHCs and FQHCs
- 80.3.1: Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions
- 80.4: Coinsurance and Deductible
- 110.3.4: RHCs/FQHCs Special Billing Instructions
- 120.1: Coding and Payment of DSMT Services
- 120.2.3: RHCs/FQHCs Special Billing Instructions
- 150.2.1: Fiscal Intermediary (FI) Billing Requirements

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25 is entitled "Completing and Processing the Form CMS-1450 Data Set." Section 75.1, "Form Locators 1-15," includes information on Type of Bill FL4 codes, including those for FQHCs and RHCs.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," contains the following sections with information specific to FQHC and RHC billing:

- 10.1: Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements
- 10.1B: A/B MAC (A) Billing Instructions
- 11.1: Electrical Stimulation

- 11.1B: FI Billing Instructions
- 11.2: Electromagnetic Therapy
- 11.2B: A/B MAC (A) Billing Instructions

MLN Matters® Article – SE1039 "Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1039.pdf
This Special Edition MLN Matters® article is based on Change Request (CR) 7038, CR 7208, and CR 8743, and it provides a billing guide for FQHCs and RHCs. It describes the information FQHCs are required to submit in order for CMS to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act.

More Resources: The Medicare Learning Network® MLN Products page at https://go.cms.gov/mln-publications-multimedia features the "Federally Qualified Health Center" and "Rural Health Clinic" fact sheets which offer additional information regarding FQHC and RHC services.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04 Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf
Chapter 9, "Rural Health Clinics/Federally Qualified Health Centers," contains the following sections with information specific to FQHC and RHC claims processing:

- 10.1: RHC General Information
- 10.2: FQHC General Information
- 20: RHC and FQHC All-Inclusive Rate (AIR) Payment System
- 20.1: Per Visit Payment and Exceptions under the AIR
- 20.2: Payment Limit under the AIR
- 30: FQHC Prospective Payment System (PPS) Payment System
- 30.1: Per-Diem Payment and Exceptions under the PPS
- 30.2: Adjustments under the PPS
- 40.1: Part B Deductible
- 40.2: Part B Coinsurance
- 50: General Requirements for RHC and FQHC Claims
- 60: Billing and Payment Requirements for RHCs and FQHCs
- 60.1: Billing Guidelines for RHC and FQHC Claims under the AIR System
- 60.2: Billing for FQHC Claims Paid Under the PPS
- 60.3: Payments for FQHC PPS Claims
- 60.4: Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
- 60.5: PPS Payments to FQHCs under Contract with MA Plans
- 70: General Billing Requirements for Preventive Services
- 70.1: RHCs Billing Approved Preventive Services
- 70.2: FQHCs Billing Approved Preventive Services under the AIR
- 70.3: FQHCs Billing Approved Preventive Services under the PPS
- 70.4: Vaccines
- 70.5: Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)
- 70.6: Initial Preventive Physical Examination (IPPE)

- 80: Telehealth Services
- 90: Services Non-covered on RHC and FQHC Claims
- 100: Frequency of Billing and Same Day Billing

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," contains specific information about payments to RHCs and FQHCs in Section 40.1.4, "Payment Requirements."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," contains information about payment for lab services provided in FQHCs and RHCs in Section 30.3, "Method of Payment for Clinical Laboratory Tests – Place of Service Variation."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Section 10, "Payment Rules for Drugs and Biologicals," includes a table titled "Drug Payment Methodology" which describes the payment calculation methodology or payment rate for various vaccines and drugs when administered by an FQHC or RHC.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," contains claims processing and payment information for FQHCs/RHCs in the following sections:

- 20.3.2.2: Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers
- 30.4.1: Payment Method for RHCs and FQHCs
- 40.5: Payment Method
- 50.3: Payment Method – FIs and Carriers
- 70.2: Payment Methodology
- 110.3: Payment
- 120.1: Coding and Payment of DSMT Services

Paper-Based Manual – "The Provider Reimbursement Manual – Part 2," Pub. 15-2 Chapter 29

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 29 is titled "Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report Form 222-92 (Instructions)." This zip file contains Form 222-92, the annual cost report freestanding FQHCs and independent RHCs must file with CMS, and instructions to providers for completing the form.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," contains the following sections with information specific to FQHC and RHC beneficiary notices:

- 130.1: Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B
- 130.1.1: Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services
- 130.1.2: Determining Provider Liability in Claims for Ancillary and Outpatient Services

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about FQHCs and RHCs. Use the search feature on the home page of this website to review these.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the terms FQHC and RHC (or Federally Qualified Health Center and Rural Health Clinic) for related questions and answers. For example, FAQ2895 addresses services provided by eligible professionals in RHCs not being billed under the Part B physician schedule and therefore, not eligible for the Medicare EHR incentive.

Electronic Mailing List – FQHC

https://list.nih.gov/cgi-bin/wa.exe?A0=FQHC-L
The FQHC electronic mailing list is administered by CMS, which emails subscribers information regarding FQHC, publications, coding, payment, and educational material.

Electronic Mailing List – Rural Health

https://list.nih.gov/cgi-bin/wa.exe?A0=RURAL-HEALTH-L
This electronic mailing list provides rural health information for Medicare Fee-For-Service providers.

Webpage – Open Door Forums – Rural Health Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_RuralHealth.html
This webpage provides information on opportunities for live dialogue between CMS and RHCs, Critical Access Hospitals (CAHs), and FQHCs.

Fact Sheet – "Federally Qualified Health Center"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243405.html
Learn about: Federally Qualified Health Center (FQHC) background and certification; FQHC services and visits; and FQHC payment and cost reports.

Fact Sheet – "Rural Health Clinic"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243500.html
Learn about Rural Health Clinic (RHC) background; RHC services; Medicare certification as a RHC; RHC visits and payments; cost reports; and annual reconciliation.

Document – "CMS Regional Office Rural Health Coordinators"

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf
This document provides the contact information for each CMS Regional Office (RO) RHC Coordinator.

INDEPENDENT DIAGNOSTIC TESTING FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Independent Diagnostic Testing Facility Medicare resources.

DEFINITION: INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

An IDTF is a fixed location or mobile entity independent of a hospital or attending or consulting physician's office in which licensed or certified nonphysician personnel (technicians) perform diagnostic tests under physician supervision.

An IDTF can be either a mobile facility or portable unit, although it usually is a mobile unit. Mobile unit typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes or trailers. A portable unit exists when a supplier transports medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.

A Portable X-Ray Supplier (PXRS) can simultaneously enroll as a mobile IDTF; a PXRS requires a State survey, while a mobile IDTF does not (although an IDTF requires a site visit). A PXRS can bill for transportation and set-up, while mobile IDTFs cannot.

A Slide Preparation Facility or a Radiation Therapy Center is not an IDTF.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," has the following sections that are relevant to IDTF enrollment or mention an IDTF:

- 15.3: National Provider Identifier (NPI)
- 15.4.2.5: Portable X-Ray Suppliers (PXRS)
- 15.5.19: IDTF Attachment
- 15.5.19.1: Independent Diagnostic Testing Facility (IDTF) Standards
- 15.5.19.2: Multi-State Independent Diagnostic Testing Facilities (IDTFs)
- 15.5.19.3: Interpreting Physicians
- 15.5.19.4: Technicians
- 15.5.19.5: Supervising Physicians
- 15.5.19.6: Desk and Site Reviews
- 15.5.19.7: Special Procedures and Supplier Types
- 15.19.1: Application Fees
- 15.19.2.2: Scope of Site Visit
- 15.20: On-site Inspections and Site Verifications
- 15.24.8: Denial Letter Guidance
- 15.27.2: Revocations

Webpage – Medicare Provider-Supplier Enrollment – Provider Enrollment Regulation

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentRegulation.html
This webpage references IDTF performance standards and regulations.

Form – Medicare Enrollment Application – Clinics/Group Practices and Certain Other Suppliers Form CMS-855B

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf
IDTFs complete this enrollment form either in the paper format or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). IDTF suppliers must complete Attachment 2.

Form – Reassignment of Medicare Benefits Form CMS-855R

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855r.pdf
This form must be completed for any interpreting physicians reassigning benefits to the IDTF.

Document – "Independent Diagnostic Testing Facility (IDTF) Performance Standards"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Independentdiagnostictestingfacility.pdf
This document contains a list of the performance standards that an IDTF must meet in order to obtain or maintain Medicare billing privileges.

Fact Sheet – "Independent Diagnostic Testing Facility (IDTF)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909060.html
This fact sheet is designed to provide education on requirements for the Independent Diagnostic Testing Facility (IDTF). It includes information on enrollment, the effective date of billing privileges, billing issues, ordering of tests, place of service issues and requirements for multi-state IDTFs, physicians, and technicians.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Survey & Certification – Accreditation of Advanced Diagnostic Imaging Suppliers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Advanced-Diagnostic-Imaging-Suppliers.html
IDTFs must become accredited to furnish the Technical Component (TC) of advanced diagnostic imaging services (defined as including diagnostic Magnetic Resonance Imaging [MRI], Computed Tomography [CT], and nuclear medicine imaging such as Positron Emission Tomography [PET]) to Medicare beneficiaries. This page provides information about the accreditation requirements and about the organizations approved by CMS to accredit to accredit suppliers, including but not limited to physicians, non-physician practitioners, and IDTFs that furnish the TC of advanced diagnostic imaging services.

MLN Matters® Article – MM7681 Revised "Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7681.pdf
This MLN Matters® article explains that accrediting organizations may provide the listing of who is accredited though a weekly file. Providers/suppliers do not need to complete the Advanced Diagnostic Imaging (ADI) information in Internet-based PECOS or on a Form CMS-855.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," includes Section 50, "Sleep Disorder Clinics," which explains these clinics may be affiliated either with a hospital or a freestanding facility. Whether a clinic is hospital-affiliated or freestanding, coverage for diagnostic services under some circumstances is covered under provisions of the law different from those for coverage of therapeutic services.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections relevant to IDTFs:

- 70: Sleep Disorder Clinics
- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.6.1: Definitions
- 80.6.2: Interpreting Physician Determines a Different Diagnostic Test is Appropriate
- 80.6.3: Rules for Testing Facility to Furnish Additional Tests
- 80.6.4: Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to IDTFs and services performed by IDTFs in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 20.15: Electrocardiographic Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 35

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c35.pdf
Chapter 35, "Independent Diagnostic Testing Facility (IDTF)," contains the following sections relevant to coverage:

- 10: General Coverage and Payment Policies
- 10.1: The Term "Independent Diagnostic Testing Facility (IDTF)"
- 10.2: Claims Processing
- 20: Ordering of Test
- 40: Interpretations Performed Off the Premises of the IDTF
- 50: Therapeutic Procedures

Fact Sheet – "Provider Compliance Tips for Computed Tomography (CT Scans)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907793.html
This fact sheet is designed to provide education on CT Scans. It includes helpful tips on how to prevent claim denials as well as documentation needed to submit a claim.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," contains the following sections relevant to IDTF billing:

- 10: Jurisdiction for Claims
- 10.1: Carrier Jurisdiction of Requests for Payment
- 10.1.1: Payment Jurisdiction Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services
- 10.1.1.2: Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation
- 30.2.9: Payment to Physician or Other Supplier for Purchased Diagnostic Tests Subject to the Anti-Markup Payment Limitation-Claims Submitted to A/B MACs (B)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section covers Items 19, 20, and 32, which have specific instructions for IDTFs related to anti-markup tests and billing using the Form CMS-1500 or electronic equivalent.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 35

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c35.pdf
Chapter 35, "Independent Diagnostic Testing Facility (IDTF)," contains the following sections relevant to IDTF billing:

- 10.2: Claims Processing
- 30: Diagnostic Tests Subject to the Anti-Markup Payment Limitation
- 30.1: National Provider Identification (NPI) Reported on Claims

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to IDTF services include:

Chapter IX Radiology Services (CPT Codes 70000-79999)
Chapter X Pathology and Laboratory Services (CPT Codes 80000-89999)

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Refer to the Hospital, Physician, and Skilled Nursing Facility (SNF) pathways for additional information regarding diagnostic testing services provided to Medicare beneficiaries outside the IDTF setting.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections, which establish jurisdiction requirements for Medicare Contractors processing IDTF claims subject to the anti-markup payment limitation:

- 10.1.1.2: Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation
- 30.2.9: Payment to Physician or Other Supplier for Purchased Diagnostic Tests Subject to the Anti-Markup Payment Limitation-Claims Submitted to A/B MACs (B)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," includes Section 20.3, "Anti-Markup Payment Limitation," which contains information about coding, technical and professional components, and specific radiologic procedures.

Webpage – Medicare Physician Fee Schedule (MPFS) Overview

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx
Purchased tests and interpretations performed in an IDTF setting are payable under the MPFS. Use this site to search the MPFS for Healthcare Common Procedure Coding System (HCPCS) codes and payment rates for IDTF services.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about IDTFs. Use the search feature on the home page of this website to review these.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Many IDTF services are considered DHS.

LABORATORY

INTRODUCTION

This curriculum is designed as a pathway to Laboratory Medicare resources.

Definition: Clinical Laboratory

Clinical laboratory services involve the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

Definition: Histocompatibility Laboratory

A histocompatibility laboratory does matching tests in preparation for procedures such as kidney transplants, bone marrow transplants, and blood platelet transfusions.

Definition: Independent Laboratory

An independent laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital.

Definition: Outpatient Hospital Laboratory

A hospital laboratory furnishes services to hospital outpatients, persons who have not been admitted by the hospital as an inpatient but are registered on the hospital records as an outpatient and receive services (rather than supplies alone) from the hospital.

Definition: Physician Office Laboratory

A physician office laboratory is a laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.

Definition: Qualified Hospital Laboratory

A qualified hospital laboratory is one that provides some clinical laboratory tests 24 hours a day, seven days a week, to serve a hospital's emergency room that is also available to provide services 24 hours a day, seven days a week.

Definition: Referring Laboratory

A Medicare-approved laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.

Definition: Reference Laboratory

A Medicare-enrolled laboratory that receives a specimen from another, referring laboratory for testing and that actually performs the test.

Webpage – Clinical Labs Center

https://www.cms.gov/Center/Provider-Type/Clinical-Labs-Center.html
The Clinical Labs Center contains helpful links to billing/payment, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, participation, contacts, and educational resources for clinical laboratory providers.

More Resources: Refer to the Hospital, Critical Access Hospital (CAH), End-Stage Renal Disease (ESRD) Facility, Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC), and Skilled Nursing Facility (SNF) pathways for laboratory services billing and payment information specific to those institutions.

ENROLLMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," includes Section 10.1, "Definitions." This section provides definitions for different types of laboratories.

Histocompatibility Laboratory

Transmittal 320 – "Provider Enrollment Revisions"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R320PI.pdf
This transmittal explains that a histocompatibility laboratory is the only type of laboratory that must enroll with the Medicare Contractor through Part A.

Independent Clinical Laboratory

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.3, "National Provider Identifier (NPI)." This section includes information regarding enrollment for independent clinical laboratories.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Clinical Laboratory Improvement Amendments (CLIA)

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html
This webpage explains that CMS regulates all laboratory testing (except research) performed on humans in the United States through CLIA. The webpage provides a link to brochures, test categorization, and a fee schedule for CLIA.

Webpage – Clincal Laboratory Improvement Amendments (CLIA) – Accreditation Organizations/Exempt States

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Accreditation_Organizations_and_Exempt_States.html
This webpage provides a link to a list of approved accreditation organizations with deeming authority under CLIA and a list of States with State licensure programs that have exemption from CLIA program requirements.

Webpage – Clincal Laboratory Improvement Amendments (CLIA) – Interpretive Guidelines for Laboratories

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Interpretive_Guidelines_for_Laboratories.html
This webpage includes survey procedures and interpretive guidelines for laboratories and laboratory services. The items listed on the page replace the current Publication 7, Appendix C, "Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services."

Webpage – Clincal Laboratory Improvement Amendments (CLIA) – CLIA Regulations and Federal Register Documents

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/CLIA_Regulations_and_Federal_Register_Documents.html
This webpage includes links to the following information concerning CLIA regulations: the most current version of the CLIA regulations Part 493; a chronological list containing online copies of the CLIA regulations and related Federal Register publications (Centers for Disease Control and Prevention [CDC] Site); the Code of Federal Regulations search feature at the Government Printing Office (GPO) Access site; and the Federal Register search feature at the GPO Access Site.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," includes the following sections which explain CLIA regulations under Medicare:

- 70.1: Background
- 70.4: CLIA Numbers
- 70.5: CLIA Categories and Subcategories
- 70.6: Certificate for Provider-Performed Microscopy Procedures
- 70.8: Certificate of Waiver

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," includes the following sections on laboratory accreditation:

- 1018H: Deemed CLIA Laboratories
- 1018I: Exemption of Laboratories Licensed by States

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections related to CLIA certification:

- 2005C: Clinical Laboratory Improvement Amendments of 1988 (CLIA) Laboratories

IOM – "State Operations Manual," Pub. 100-07, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c06.pdf
Chapter 6, "Special Procedures for Laboratories," is completely devoted to laboratory information. This chapter provides the background and actions related to certification, sample validation surveys of accredited laboratories, sample validation surveys of CLIA-exempt laboratories, validation surveys performed simultaneously with accreditation organization inspections or approved State program inspections, other activities, adverse actions, and budget and administration information.

IOM – "State Operations Manual," Pub. 100-07, Appendix C

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_c_lab.pdf
Appendix C, "Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services," includes policy for conducting surveys.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections which explain what is necessary for CLIA and Medicare enrollment:

- 15.3: National Provider Identifier (NPI)
- 15.4.2.2: CLIA Labs

Website – U.S. Food and Drug Administration

http://www.fda.gov/default.htm
The U.S. Food and Drug Administration (FDA) determines the testing categories of tests that they have cleared for clinical use using a scoring system that takes into account the complexity of the testing, stability of calibrators, controls, pre-analytic steps required, and need for interpretation of results. A complete listing is available at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/search.cfm on the FDA's website.

Fact Sheet – "Clinical Laboratory Improvement Amendments (CLIA)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243307.html
This fact sheet is designed to provide education on the CLIA program, including test categories, how to enroll, types of certificates, and CLIA proficiency testing. It includes information on the coverage of Medicare laboratory services separate from CLIA.

COVERAGE

Webpage – Medicare Coverage – General Information – Lab NCDs – ICD-10

https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html
This webpage provides information on National Coverage Determinations (NCDs) for clinical diagnostic laboratory services.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections about coverage for laboratory services:

- 80: Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
- 80.1: Clinical Laboratory Services
- 80.1.1: Certification Changes
- 80.1.2: Carrier Contacts With Independent Clinical Laboratories
- 80.1.3: Independent Laboratory Service to a Patient in the Patient's Home or an Institution
- 80.6.1: Definitions
- 250: Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities
- 260.2: Ambulatory Surgical Center Services
- 260.3: Services Furnished in ASCs Which are Not ASC Facility Services
- 260.4: Coverage of Services in ASCs, Which are Not ASC Services

More Resources: Refer to the CMS Preventive Services Provider Resources webpage at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html for additional resources regarding screening laboratory tests such as the Pap test.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes reference to a laboratory in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf

- 190.1: Histocompatibility Testing
- 190.2: Diagnostic Pap Smears
- 190.3: Cytogenetic Studies
- 190.4: Electron Microscope
- 190.5: Sweat Test
- 190.6: Hair Analysis
- 190.7: Human Tumor Stem Cell Drug Sensitivity Assays
- 190.8: Lymphocyte Mitogen Response Assays
- 190.9: Serologic Testing for Acquired Immunodeficiency Syndrome (AIDS)
- 190.10: Laboratory Tests – CRD Patients
- 190.11: Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management – (Effective March 19, 2008)
- 190.12: Urine Culture, Bacterial
- 190.13: Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring)
- 190.14: Human Immunodeficiency Virus (HIV) Testing (Diagnosis)
- 190.15: Blood Counts
- 190.16: Partial Thromboplastin Time (PTT)
- 190.17: Prothrombin Time (PT)
- 190.18: Serum Iron Studies
- 190.19: Collagen Crosslinks, Any Method
- 190.20: Blood Glucose Testing
- 190.21: Glycated Hemoglobin/Glycated Protein
- 190.22: Thyroid Testing
- 190.23: Lipid Testing
- 190.24: Digoxin Therapeutic Drug Assay
- 190.25: Alpha-fetoprotein
- 190.26: Carcinoembryonic Antigen
- 190.27: Human Chorionic Gonadotropin
- 190.28: Tumor Antigen by Immunoassay – CA 125
- 190.29: Tumor Antigen by Immunoassay CA 15-3/CA 27.29
- 190.30: Tumor Antigen by Immunoassay CA 19-9
- 190.31: Prostate Specific Antigen
- 190.32: Gamma Glutamyl Transferase
- 190.33: Hepatitis Panel/Acute Hepatitis Panel
- 190.34: Fecal Occult Blood Test

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf

Chapter 16, "Laboratory Services," includes the following sections which explain Medicare coverage policies for laboratory services:

- 10: Background
- 110.4: A/B MAC (B) Contacts With Independent Clinical Laboratories
- 120: Clinical Laboratory Services Based on the Negotiated Rulemaking
- 120.2: Implementation and Updates of Negotiated National Coverage Determinations (NCDs) or Clinical Diagnostic Laboratory Services

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," includes the following sections related to submitting laboratory claims:

- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services
- 180.1: Background and Policy

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf

Chapter 16, "Laboratory Services," includes the following sections which explain billing for laboratory services:

- 30.1: Mandatory Assignment for Laboratory Tests
- 30.1.1: Rural Health Clinics
- 40.1: Laboratories Billing for Referred Tests
- 40.1.1: Claims Information and Claims Forms and Formats
- 40.1.1.1: Paper Claim Submission to A/B MACs (B)
- 40.1.1.2: Electronic Claim Submission to A/B MACs (B)
- 40.2: Payment Limit for Purchased Services
- 40.3: Hospital Billing Under Part B
- 40.4: Special Skilled Nursing Facility (SNF) Billing Exceptions for Laboratory Tests
- 40.4.1: Which A/B MAC (A) or (B) to Bill for Laboratory Services Furnished to a Medicare Beneficiary in a Skilled Nursing Facility (SNF)
- 40.5: Rural Health Clinic (RHC) Billing
- 40.7: Billing for Noncovered Clinical Laboratory Tests
- 40.8: Date of Service (DOS) for Clinical Laboratory and Pathology Specimens
- 50.2.1: Assignment Required
- 50.5: Jurisdiction of Laboratory Claims
- 50.5.1: Jurisdiction of Referral Laboratory Services
- 50.5.2: Examples of Independent Laboratory Jurisdiction Rules
- 60.1.4: Coding Requirements for Specimen Collection
- 70.2: Billing
- 70.9: HCPCS Subject To and Excluded From CLIA Edits
- 70.10: CLIA Number Submitted on Claims from Independent Labs
- 80.2: Anatomic Pathology Services
- 80.2.1: Technical Component (TC) of Physician Pathology Services to Hospital Patients
- 80.4: Oximetry
- 90: Automated Profile Tests and Organ/Disease Oriented Panels
- 90.5: Special Processing Considerations
- 100.4: Not Otherwise Classified Clinical Laboratory Tests
- 100.5.1: Tests Performed More Than Once on the Same Day
- 100.6: Pricing Modifiers
- 120.1: Negotiated Rulemaking Implementation

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes the following sections which explain billing for laboratory services:

- 10: Reporting ICD Diagnosis and Procedure Codes
- 20: Description of Healthcare Common Procedure Coding System (HCPCS)
- 20.9.1.1: Instructions for Codes With Modifiers (A/B MACs (B) Only)
- 100.5: Adjustments to the Single Payment Amounts to Reflect Changes in HCPCS Codes

MLN Matters® Article – SE1105 Revised "Medicare Drug Screen Testing"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1105.pdf
This Special Edition MLN Matters® article describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the Clinical Laboratory Fee Schedule (CLFS).

Histocompatibility Laboratory

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 20, "Provider Assignment to FIs and MACs." This section indicates to which Medicare Contractor jurisdiction the histocompatibility laboratory will bill claims.

Independent Laboratory

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections related to submitting independent laboratory claims:

- 10.1: Carrier Jurisdiction of Requests for Payment
- 10.1.5.4: Independent Laboratories
- 10.1.5.4.1: Cases Involving Referral Laboratory Services

Independent Laboratory and Physician Office Laboratory

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections related to mandatory assignment for independent and physician office laboratory claims:

- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.6: Mandatory Assignment Requirement for Physician Office Laboratories on Claims Submitted to Carriers

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," includes Section 10.4, "Items 14-33 – Provider of Service or Supplier Information." This section includes billing requirements specific to laboratories using the Form CMS-1500 or electronic equivalent.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 10.1.1, "Payment Jurisdictions Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services." This section explains that clinical laboratory services are not paid under the Medicare Physician Fee Schedule (MPFS).

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," includes the following sections which explain claims processing and payment for laboratory claims:

- 10.2: General Explanation of Payment
- 20: Calculation of Payment Rates – Clinical Laboratory Test Fee Schedules
- 20.1: Initial Development of Laboratory Fee Schedules
- 20.2: Annual Fee Schedule Updates
- 30.2: Deductible and Coinsurance Application for Laboratory Tests
- 30.3: Method of Payment for Clinical Laboratory Tests – Place of Service Variation
- 30.4: Payment for Review of Laboratory Test Results by Physician
- 40.3.1: Critical Access Hospital (CAH) Outpatient Laboratory Service
- 50.1: Referring Laboratories
- 50.2: Physicians
- 50.3.1: Hospital-Leased Laboratories
- 50.4: Reporting of Pricing Localities for Clinical Laboratory Services
- 60.1: Specimen Collection Fee
- 60.1.1: Physician Specimen Drawing
- 60.1.2: Independent Laboratory Specimen Drawing
- 60.1.3: Specimen Drawing for Dialysis Patients
- 60.2: Travel Allowance
- 70.3: Verifying CLIA Certification
- 70.10.1: Physician Notification of Denials
- 70.11: Reasons for Denial – Physician Office Laboratories Out-of-Compliance
- 80.1: Screening Services
- 80.3: National Minimum Payment Amounts for Cervical or Vaginal Smear Clinical Laboratory Tests
- 90.1: Laboratory Tests Utilizing Automated Equipment
- 90.1.1: Automated Test Listing
- 90.2: Organ or Disease Oriented Panels
- 90.3: Claims Processing Requirements for Panel and Profile Tests
- 90.3.1: History Display
- 90.3.2: Medicare Secondary Payer
- 90.4: Evaluating the Medical Necessity for Laboratory Panel CPT Codes
- 100: CPT Codes Subject to and Not Subject to the Clinical Laboratory Fee Schedule
- 100.2: Laboratory Tests Never Subject to the Fee Schedule
- 100.3: Procedures Not Subject to Fee Schedule When Billed With Blood Products
- 110.1: Coordination Between A/B MACs (B) and A/B MACs (A)/RRB
- 110.2: Coordination With Medicaid
- 110.3: Coordination With A/B MACs (A) and Providers

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Chapter 23, "Fee Schedule Administration and Coding Requirements," includes the following sections which explain fee schedules and payment for laboratory services:

- 30: Services Paid Under the Medicare Physician's Fee Schedule
- 40: Clinical Diagnostic Laboratory Fee Schedule
- 40.1: Access to Clinical Diagnostic Lab Fee Schedule Files
- 40.2: A/B MAC (B) Record Layout for Clinical Laboratory Fee Schedule
- 40.3: Institutional Claim Record Layout for Clinical Laboratory Fee Schedule

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 35

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c35.pdf
Chapter 35, "Independent Diagnostic Testing Facility (IDTF)," includes Section 10.2, "Claims Processing." This section explains slide preparation facilities are not IDTFs. Slide preparation facilities are entities that provide slide preparation services and other kinds of services that are payable through the technical component of the surgical pathology service.

Webpage – Clinical Laboratory Fee Schedule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html
This webpage provides links to the clinical laboratory fee schedule files, regulations and notices, laboratory public meetings, Code of Federal Regulation (CFR) citations, and relevant clinical laboratory transmittals.

Webpage – CMS Forms

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
This webpage includes a link to the Form CMS-209, the Laboratory Personnel Report (CLIA). Go to Filter On and search for 209 to access the form.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapters relevant to laboratory services include:

Chapter I: General Correct Coding Policies
Chapter X: Pathology and Laboratory Services (CPT Codes 80000-89999)

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Fact Sheet – "Clinical Laboratory Fee Schedule"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243659.html
Learn about: background; coverage of clinical laboratory services; how payment rates are set; and updates to the Clinical Laboratory Fee Schedule.

MLN Matters® Article – MM8132 Revised "Calendar Year (CY) 2013 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8132.pdf
This MLN Matters® article provides instructions to Medicare Contractors for the Calendar Year (CY) 2013 Clinical Laboratory Fee Schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Histocompatibility Laboratory

Paper-Based Manual – "The Provider Reimbursement Manual-Part 2," Pub. 15-2, Chapter 33

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 33, "Organ Procurement & Histo Lab (Form CMS 216-94, Instructions & Specifications)," includes information on the completion of Form CMS-216-94 for cost reporting for a histocompatibility laboratory.

Webpage – CMS Forms

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
This webpage includes a link to the Form CMS-216-94, the Organ Procurement Organization–Histo-Compatibility Lab Statement of Reimbursable Costs. Go to Filter On and search for 216 to access the form.

Federal Register – Payment of Independent Organ Procurement Organizations and Histocompatibility Laboratories

http://cfr.vlex.com/vid/413-200-organ-histocompatibility-laboratories-19802962
This section of the Federal Register includes information on payment for a histocompatibility laboratory.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections related to Advance Beneficiary Notices (ABNs) for laboratory services:

- 40.3.4.1: Basic Delivery Requirements
- 40.3.4.5: Identification of Notifier
- 40.3.6.4: Routine ABN Prohibition Exceptions
- 50: Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)
- 50.4.1: Issuers of ABNs (Notifiers)
- 50.6.3: Completing the ABN
- 50.6.4: Retention Requirements

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Clinical Laboratory Improvement Amendments (CLIA) – Laboratory Registry

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Laboratory_Registry.html
This webpage makes available to physicians and the general public specific information (including information provided to CMS by the Office of Inspector General [OIG]) that is useful in evaluating the performance of a laboratory.

Webpage – Clinical Laboratory Improvement Amendments (CLIA) – Code of Federal Regulations Citations

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Code-of-Federal-Regulation-Citations.html
This webpage shows the CFR citations for clinical laboratory information.

Webpage – Transmittals

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
This webpage allows you to select the Transmittal year, then filter on 'Clinical Laboratory' for transmittals related to the clinical lab provider community.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Clinical laboratory services are considered DHS.

Webpage – Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term lab for related questions and answers. For example, FAQ2855 explains the incorporation of clinical lab test results into EHR structured data.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports on laboratory subjects such as the clinical laboratory fee schedule and independent laboratories. Use the search feature on the home page of this website to review these.

Electronic Mailing List – Laboratory Services

https://list.nih.gov/searchlsv.html
There are numerous electronic mailing lists administered by the National Institutes of Health used to distribute laboratory information. In the Search field, type lab to find relevant electronic mailing lists.

Webpage – Open Door Forums – End-Stage Renal Disease and Clinical Laboratories Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_ESRD.html
This webpage provides information on opportunities for live dialogue between CMS and laboratories.

MAMMOGRAPHY CENTER OR FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Mammography Center or Facility Medicare resources.

DEFINITION: MAMMOGRAPHY CENTER OR FACILITY

A Mammography Center or Facility provides screening and diagnostic mammography services to Medicare beneficiaries. The Mammography Quality Standards Act (MQSA) requires that, before a Mammography Center or Facility can legally perform mammography, it must be certified by the Food and Drug Administration (FDA) or qualified States under the States As Certifiers (SAC) program. Before a facility can be certified, it must be accredited by a federally approved private nonprofit or state accreditation body as well as meet certification requirements.

More Resources: Refer to other pathways such as Hospital, Independent Diagnostic Testing Facility (IDTF), and Portable X-ray Supplier (PXRS) for additional provider-specific information about billing and claims processing/payment for mammography services for Medicare beneficiaries. Information on reporting Physician Quality Reporting System measures, which include mammography screening, is available in the Physician and Other Enrolled Health Care Professionals pathway.

ENROLLMENT

Webpage – Radiation-Emitting Products – Mammography Quality Standards Act and Program

http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm
This U.S. Food and Drug Administration (FDA) webpage includes a search feature and What's New section about the MQSA.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes Section 20.1, "Certification of Mammography Facilities," which explains the specific standards MQSA provides regarding those qualified to perform screening and diagnostic mammograms and how they should be certified.

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes Section 2460, "Screening Mammography," which explains that MQSA requires all facilities providing diagnostic and screening mammography services to have a certificate issued by the FDA, regardless of the source of payment and do not undergo a Medicare survey.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections that mention Mammography Centers:

- 15.3: National Provider Identifier (NPI)
- 15.4.2.3: Mammography Screening Centers
- 15.23.3: File Maintenance

Form – Medicare Enrollment Application – Clinics/Group Practices and Certain Other Suppliers Form CMS-855B

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf
A non-institutional supplier or clinic which will bill for mammography on a Form CMS-1500 or its electronic equivalent must enroll as a mammography center and include FDA/Radiology (Mammography) Certification Number(s) for the location.

Form – Medicare Enrollment Application – Institutional Providers Form CMS-855A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
An institutional provider that will bill for mammography on a Form CMS-1450 or its electronic equivalent must enroll and include the FDA/Radiology (Mammography) Certification Number(s) for the location.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Radiation-Emitting Products – Accreditation and Certification Overview

http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Guidance/PolicyGuidanceHelpSystem/ucm049115.htm
This page describes the FDA certification process for Mammography Centers, and includes provider discussion forums and a list of questions and answers.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 90.1 "Supplier Defined," which states that mammography facilities are a supplier that must meet conditions in order to receive Medicare payment.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 280.3, "Screening Mammography," which defines coverage of this screening procedure.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections relevant to mammography coverage:

- 20: Mammography Services (Screening and Diagnostic)
- 20.1: Certification of Mammography Facilities
- 20.1.1: Services Under Arrangements
- 20.1.2: FDA Certification Data

More Resources: Refer to the CMS Preventive Services Provider Resources webpage at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html for additional information regarding mammography services covered by Medicare.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," includes the following sections with reference to mammography:

- 20.3: Anti-Markup Payment Limitation
- 20.3.2: Billing for Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections relevant to mammography billing:

- 20.2: HCPCS and Diagnosis Codes for Mammography Services
- 20.2.1: Computer-Aided Detection (CAD) Add-On Codes
- 20.2.1.1: CAD Billing Charts
- 20.4: Billing Requirements – FI/A/B MAC Claims
- 20.4.1.1: RHC/FQHC Claims With Dates of Service Prior to January 1, 2002
- 20.4.1.2: RHC/FQHC Claims With Dates of Service on or After January 1, 2002
- 20.4.2: FI Requirements for Nondigital Screening Mammographies
- 20.5: Billing Requirements – A/B MAC (B) Claims
- 20.6: Instructions When an Interpretation Results in Additional Films
- 20.7: Mammograms Performed With New Technologies

Non-Institutional Billers Only

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
A certified mammography screening center enters the 6-digit FDA approved certification number in Item 32 on Form CMS-1500 or its electronic equivalent.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections relevant to mammography claims processing and payment:

- 20.1: Certification of Mammography Facilities
- 20.1.2: FDA Certification Data
- 20.3: Payment
- 20.3.1: Payment for Screening Mammography Services Provided Prior to January 1, 2002
- 20.3.2: Payment for Screening Mammography Services Provided On or After January 1, 2002
- 20.3.2.1: Outpatient Hospital Mammography Payment Table
- 20.3.2.2: Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers
- 20.3.2.3: Critical Access Hospital Payment
- 20.3.2.3.1: CAH Screening Mammography Payment Table
- 20.3.2.4: SNF Mammography Payment Table

- 20.4.2.1: FI Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)
- 20.5.1: Part B Carrier Claim Record for CWF
- 20.5.1.1: Carrier and CWF Edits
- 20.5.2: Transportation Costs for Mobile Units
- 20.8.1: MSN Messages
- 20.8.2: Remittance Advice Messages

Non-Institutional Remittance Advices Only

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes Section 80.3.2.1.3, "A/B MAC (B) Specific Requirements for Certain Specialties/Services," which lists the remark code that is used when the FDA number is omitted on a Form CMS-1500 or electronic equivalent claim.

Fact Sheet – "Reading a Professional Remittance Advice"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908328.html
Learn about reading a Professional Electronic Remittance Advice (ERA); reading a Standard Paper Remittance Advice (SPR); and balancing the ERA or SPR so provider records are consistent with Medicare's records.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 20.1.1, "Statutory Basis," that explains the claims payment and beneficiary indemnification provisions of the limitation on liability provision regarding screening mammography that is performed more frequently than is covered or that is not conducted by a MSQA certified facility.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Electronic Mailing List – FDA Mammography

https://public.govdelivery.com/accounts/USFDA/subscriber/new?topic_id=USFDA_45
The electronic mailing list is administered by the FDA, which emails subscribers information regarding mammography.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about mammography. Use the search feature on the home page of this website to review these.

Webpage – Radiation-Emitting Products – Search for a Certified Facility

http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/ConsumerInformation/ucm113962.htm

This page contains a link called Search for MQSA Certified Mammography Facilities in Your Area, from which providers can access a listing by ZIP code of all mammography facilities in that ZIP code certified by the FDA or certifying State as meeting baseline quality standards for equipment, personnel, and practices under the MQSA and subsequent Mammography Quality Standards Reauthorization Act (MQSRA) amendments.

MASS IMMUNIZATION ROSTER BILLER

INTRODUCTION

This curriculum is designed as a pathway to Mass Immunization Roster Biller Medicare resources. A variety of professionals, suppliers, and providers can be mass immunizers and much of this information may be helpful to them. However, for the purpose of this pathway, only those entities that enroll in Medicare just to provide mass immunizations will be discussed.

DEFINITION: MASS IMMUNIZATION ROSTER BILLER

A Mass Immunization Roster Biller is an individual or entity who offers seasonal influenza virus and/or pneumococcal vaccines to a large number of individuals and chooses to enroll in Medicare to bill only for these vaccinations.

DEFINITION: CENTRALIZED BILLER

A centralized biller is an individual or entity who provides mass immunization services for seasonal influenza virus and pneumococcal immunizations and can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Services.)

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.6.2, "Mass Immunizers Who Roster Bill." This section explains that an entity or individual who wishes to furnish mass immunization services but may not otherwise qualify as a Medicare provider, may be eligible to enroll as a mass immunizer via the Form CMS-855I (individuals) or the Form CMS-855B (entities).

COVERAGE

Guide – "2012-2013 Immunizers' Question & Answer Guide to Medicare Part B, Medicaid and CHIP Coverage of Seasonal Influenza and Pneumococcal Vaccinations"

https://www.cms.gov/Medicare/Prevention/Immunizations/Downloads/2012-2013_Flu_Guide.pdf
This document addresses immunizers' commonly asked questions about the administration of seasonal influenza virus and pneumococcal vaccines to Medicare beneficiaries. There is a section devoted to mass immunizers/roster billers.

More Resources: Refer to the CMS Preventive Services Provider Resources webpage at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html for additional resources regarding preventive immunizations covered by Medicare.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections which explain billing for mass immunization services:

- 20: Provider Assignment to FIs and MACs
- 30.3.1: Mandatory Assignment on Carrier Claims

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes Section 10.3, "Simplified Roster Claims for Mass Immunizers," which explains mass immunization and roster billing for influenza virus and pneumococcal vaccines.

Fact Sheet – "Mass Immunizers and Roster Billing"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254400.html
Learn about requirements for mass immunizers; roster billing; and centralized billing.

MLN Matters® Articles – MM7884 Revised "New Non-Physician Specialty Code for Centralized Flu"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7884.pdf
This MLN Matters® article explains that CMS established a new non-physician practitioner specialty code for Centralized Flu effective January 1, 2013. The new non-physician practitioner specialty code for Centralized Flu is C1 and is only applicable to the CMS-855B enrollment application.

PORTABLE X-RAY SUPPLIER

INTRODUCTION

This curriculum is designed as a pathway to Portable X-Ray Supplier Medicare resources.

DEFINITION: PORTABLE X-RAY SUPPLIER (PXRS)

A PXRS moves its x-ray equipment from place to place, performing x-ray services at various locations. A PXRS can be either a mobile facility or portable unit, although it usually is the latter. Mobile unit typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes or trailers. A portable unit exists when a supplier transports medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.

To qualify as a PXRS, an entity must meet the conditions for coverage. These include, but are not limited to:

- Possess a State license or registration to perform the services (assuming the State licenses/registers PXRSs);
- All personnel operating the equipment are licensed/registered in accordance with State and local laws (and meet certain other training requirements);
- All PXRS equipment is licensed/registered in accordance with State and local laws;
- All suppliers of PXRS agree to render such services in conformity with Federal, State and local laws relating to safety standards; and
- The PXRS services are provided under the supervision of a qualified physician. Additionally, the supervising physician must either:
  - Own the equipment (which must be operated only by his/her employees); or
  - Certify on a yearly basis that he/she periodically checks the procedural manuals and observes the operators' performance, and that the equipment and personnel meet all Federal, State, and local requirements.
- The PXRS's services are provided under the supervision of a licensed doctor of medicine or osteopathy who is qualified in advanced training and experience in the use of x-rays for diagnostic purpose;
- The PXRS has an orientation program for its personnel; and
- All equipment is inspected at least every 2 years.

A PXRS can be simultaneously enrolled as a mobile Independent Diagnostic Testing Facility (IDTF), though it cannot bill for the same service. Note that PXRS require a State survey, while mobile IDTFs do not (although IDTFs do require a site visit). Moreover, PXRSs can bill for transportation and set-up, while mobile IDTFs cannot.

ENROLLMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Chapter 1, "General Billing Requirements," Section 30.3.12, "Carrier Annual Participation Program," outlines the procedures for PXRSs entering into a participation agreement with the Centers for Medicare & Medicaid Services (CMS) and includes the following sections:

- 30.3.12: Carrier Annual Participation Program
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.2: Carrier/MACs Participation Agreement
- 30.3.12.3: Carrier Rules for Limiting Charge

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections pertinent to PXRS enrollment:

- 15.3: National Provider Identifier (NPI)
- 15.4.2.5: Portable X-Ray Suppliers (PXRS)
- 15.5.2.1: Licenses and Certifications
- 15.5.4.2: Section 4 of the CMS-855B
- 15.7.8: Special Processing Guidelines for Independent CLIA Labs, Ambulatory Surgical Centers and Portable X-ray Suppliers
- 15.7.8.2: Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) – Initial Enrollment
- 15.7.8.3: Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Changes of Ownership (CHOWs)
- 15.7.8.3.1: Examining Whether a CHOW May Have Occurred
- 15.7.8.6: State Surveys and the Form CMS-855B
- 15.10.2: Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers

Form – Medicare Enrollment Application – Clinics/Group Practices and Certain Other Suppliers Form CMS-855B

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf
PXRSs must complete the Enrollment Application, Form CMS-855B, either as a paper form or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). One of the most important parts of any PXRS's enrollment application is Section 4.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections with information specific to the State Survey and Regional Office (RO) certification of a PXRS:

- 2420: Suppliers of Portable X-Ray Services – Citations
- 2422: Location of Portable X-Ray Service
- 2424A: Labeling Requirements
- 2424B: Request for and Review of Labeling Information

IOM – "State Operations Manual," Pub. 100-07, Exhibit 63

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_063.pdf
Exhibit 63, "List of Documents in Certification Packet," includes Section XIII, "Portable X-Ray," which provides, by title and form number, a list of forms required for certification and recertification of a PXRS.

IOM – "State Operations Manual," Pub. 100-07, Appendix D

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_d_xray.pdf
Appendix D, "Guidance to Surveyors: Portable X-Ray Services," provides information important to PXRSs, including a list of pertinent transmittals.

Form – Request For Certification As Supplier of Portable X-Ray Services Under The Medicare/Medicaid Program

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1880.pdf
Submission of this form by a PXRS requesting certification will initiate the process to verify that all conditions of coverage have been met.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 08

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," includes Section 70.1, "Diagnostic Services and Radiological Therapy," which outlines coverage requirements for portable x-ray services provided in a Skilled Nursing Facility (SNF).

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," outlines Medicare coverage for diagnostic x-ray services furnished by a PXRS in a place or residence used as the beneficiary's home and in nonparticipating institutions under the general (but not direct) supervision of a physician in the following sections:

- 80.4.1: Diagnostic X-Ray Tests
- 80.4.2: Applicability of Health and Safety Standards
- 80.4.3: Scope of Portable X-Ray Benefit
- 80.4.4: Exclusions From Coverage as Portable X-Ray Services
- 80.4.5: Electrocardiograms

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections with information about PXRSs:

- 10.1.5.2: Supplier of Portable X-Ray, EKG, or Similar Portable Services
- 30.3.12: Carrier Annual Participation Program
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," includes the following sections with billing information specific to PXRSs:

- 20.3.2: Billing for Services
- 90: Services of Portable X-Ray Suppliers
- 90.1: Professional Component
- 90.2: Technical Component
- 90.3: Transportation Component (HCPCS Codes R0070 – R0076)
- 90.4: Set-Up Component (HCPCS Code Q0092)
- 90.5: Transportation of Equipment Billed by a SNF to a MAC

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," has information specific to PXRS billing in the following sections:

- 10.1.5.2: Supplier of Portable X-Ray, EKG, or Similar Portable Services
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
In Chapter 12, "Physician/Nonphysician Practitioners," Section 20.4.1, "Participating Versus Nonparticipating Differential," explains the rule under which payments to any nonparticipating PXRS may not exceed 95 percent of the fee schedule amount or other payment basis for the service/supply.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," includes the following sections with claims processing and payment information relevant to PXRSs:

- 20.1: Professional Component (PC)
- 20.2: Technical Component (TC)
- 20.2.1: Hospital and Skilled Nursing Facility (SNF) Patients
- 20.2.2: Services Not Furnished in Hospitals
- 20.2.3: Services Furnished in Leased Departments
- 20.3: Anti-Markup Payment Limitation
- 20.3.1: A/B MAC (B) Payment Rules

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes Section 20.5.2, "Transportation Costs for Mobile Units," which addresses payment of the transportation costs for mobile mammography units as PXRSs.

More Resources: Refer to the Mammography Center or Facility pathway for more information on billing and payment of mobile mammography units.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes information specific to claims processing and payment for PXRSs in these sections:

- 30.3.2: A/B MAC (A), (B), or (HHH) Furnishing Physician Fee Schedule Data for National Codes
- 30.5: Payment Amounts for Portable X-Ray Transportation Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 26

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Chapter 26, "Completing and Processing Form CMS-1500 Data Set," contains the following sections with specific information for PXRSs when completing Form CMS-1500 or its electronic equivalent:

- 10.4: Items 14-33 – Provider of Service or Supplier Information
- 10.8.3: Nonphysician Practitioner, Supplier, and Provider Specialty Codes

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 35

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c35.pdf
Chapter 35, "Independent Diagnostic Testing Facility (IDTF)," includes Section 10, "General Coverage and Payment Policies," which states that diagnostic tests performed by PXRSs are paid under the physician fee schedule.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about portable x-ray suppliers (PXRSs). Use the search feature on the home page of this website and search the term 'portable x-ray' to review these.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the terms portable x-ray, portable x-ray suppliers, or PXRS for related questions and answers. For example, FAQ8215 explains how technical and professional components of imaging services are affected by edits for the ordering or referring physician.

Webpage – CFR – Code of Federal Regulations Title 21

http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?fr=892.1720
This webpage offers a description of a mobile x-ray system.

RADIATION THERAPY CENTER

INTRODUCTION

This curriculum is designed as a pathway to Radiation Therapy Center Medicare resources.

DEFINITION: RADIATION THERAPY CENTER (RTC)

An RTC is a freestanding clinic that offers radiation therapy, also called radiation oncology or radiotherapy, and sometimes abbreviated to XRT, which is the medical use of ionizing radiation as part of cancer treatment to control malignant cells.

ENROLLMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 35

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c35.pdf
Chapter 35, "Independent Diagnostic Testing Facility (IDTF)," includes Section 10.2, "Claims Processing." This section states that an RTC provides therapeutic services and is not an IDTF. An RTC must enroll separately with the Medicare Contractor.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.2.6, "Radiation Therapy Centers."

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes Section 90, "X-Ray, Radium, and Radioactive Isotope Therapy." This section explains x-ray, radium, and radioactive isotope therapy furnished in a non-provider facility require direct personal supervision of a physician.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes a reference to radiation therapy in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf
- 110.1: Hyperthermia for Treatment of Cancer
- 110.21: Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 230.9: Cryosurgery of Prostate

BILLING

Webpage – Skilled Nursing Facilities PPS – Consolidated Billing

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html
CMS has identified specific types of outpatient hospital services that are so exceptionally intensive, costly, or emergent that they fall well outside the typical scope of Skilled Nursing Facility (SNF) care plans. The Centers for Medicare & Medicaid Services (CMS) has excluded these services from SNF Consolidated Billing (CB). These excluded service categories include radiation therapy services.

Document – "General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing"

https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2013MajorCatExpl.pdf
This document explains radiation therapy is an excluded service beyond the scope of a SNF.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Chapter 13, "Radiology Services and Other Diagnostic Procedures," includes the following sections on billing and payment for radiation oncology (therapeutic radiology), including what services are included in radiation therapy management:
- 20.2.2: Services Not Furnished in Hospitals
- 50.1: Payments for Radionuclides
- 70.1: Weekly Radiation Therapy Management (CPT 77419 – 77430)
- 70.2: Services Bundled Into Treatment Management Codes
- 70.3: Radiation Treatment Delivery (CPT 77401 – 77417)
- 70.4: Clinical Brachytherapy (CPT Codes 77750 – 77799)
- 70.5: Radiation Physics Services (CPT Codes 77300 – 77399)

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Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter IX, "Radiology Services (CPT Codes 70000-79999)," includes principles for correct coding for radiation oncology services.

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OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Radiation therapy services and supplies are considered DHS.

Electronic Mailing List – Cancer

https://list.nih.gov/searchlsv.html
There are a number of cancer-related electronic mailing lists administered by CMS which email subscribers information regarding drug information summaries, research, and beneficiary education publications on various types of cancer. In the Search field, type cancer to find relevant electronic mailing lists.

PROVIDERS

Definition: Provider

Provider is defined in the Federal regulations and generally means a hospital, Critical Access Hospital (CAH), Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Home Health Agency (HHA) or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish Outpatient Physical Therapy (OPT) or speech pathology services; or a Community Mental Health Center (CMHC) that has in effect a similar agreement but only to furnish partial hospitalization services.

The law defines the term provider of services (or provider) as:

- A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of the law (or meets the requirements of such section through the operation of the law), or if, in the case of a public health agency, such agency meets the requirements of the law (or meets the requirements of such section through the operation of the law), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of the law) with respect to the furnishing of outpatient occupational therapy services
- A CMHC (as defined in the law), but only with respect to the furnishing of partial hospitalization services (as described in the law)

More Resources: Pharmacies billing Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through Durable Medical Equipment (DME), submit claims to the Medicare Administrative Contractor. For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) pathway.

Webpage – Medicare Provider-Supplier Enrollment

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html
This enrollment webpage provides a link to Enrollment Applications which offers more information on application submission. Facilities must complete the Medicare Enrollment Application for Institutional Providers, Form Centers for Medicare & Medicaid Services (CMS)-855A, either as a paper form or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

COMMUNITY MENTAL HEALTH CENTER

INTRODUCTION

This curriculum is designed as a pathway to Community Mental Health Center Medicare resources.

DEFINITION: COMMUNITY MENTAL HEALTH CENTER (CMHC)

A CMHC is a facility that provides mental health services and performs the following core services:

- Outpatient services (This includes services for children, the elderly, persons who are chronically mentally ill, and certain persons who have been discharged from a mental health facility for inpatient treatment.)
- 24-hour-a-day emergency psychiatric services
- Day treatment or other Partial Hospitalization (PH) services, or psychosocial rehabilitation services
- Screening for beneficiaries being considered for admission to State mental health facilities

A CMHC is an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides all of the core services to meet the statutory definition of a CMHC. In the case of an entity operating in a State that by law precludes the entity from providing the screening services, the entity may provide for such service by contract with an approved organization or entity (as determined by the Secretary) that, among other things, meets applicable licensure or certification requirements for CMHCs in the State in which it is located. A CMHC may get Medicare payment for partial hospitalization services only if it demonstrates that it provides such services.

A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, it must service a distinct and definable community. A CMHC (or CMHC site) that operates outside of this specific community must (unless the Centers for Medicare & Medicaid Services [CMS] Regional Office holds otherwise) have a separate provider agreement/number and enrollment, and must individually meet all Medicare requirements.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections related to the provider agreement a CMHC must sign to provide partial hospitalization services billed to Medicare:

- 10: Part A Provider and Related Definitions
- 10.1: Provider Agreements
- 10.1.1: Basic Commitment in Provider Agreement
- 10.1.3: Part B Deductible and Coinsurance
- 10.3: Under Arrangements
- 10.4: Term of Agreements
- 10.6: Termination of Provider Participation
- 10.6.1: Voluntary Termination
- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement
- 10.6.5: Change of Provider Ownership

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," contains the following sections pertaining to the certification of a CMHC:

- 2008C: New CMHC Applicants
- 2250: Community Mental Health Centers (CMHC) – Citations and Descriptions
- 2250A: General
- 2250B: Special Requirements
- 2250C: Community Mental Health Centers
- 2250D: Partial Hospitalization Program (PHP)
- 2250E: Partial Hospitalization Services Provided by CMHCs or by Others Under Arrangements With the CMHC
- 2250F: Definitions of Core Services
- 2250G: Threshold and Service Requirements for CMHCs
- 2250H: Revisions to the Core Service Screening Requirements as the Result of the Passage of BIPA
- 2252: Certification Process
- 2252A: General
- 2252B: Request to Participate
- 2252C: Information to be Sent to CMHC Applicant
- 2252D: Processing CMHC Requests, FI Role
- 2252E: Processing CMHC Requests, SA Role
- 2252F: Processing CMHC Requests, RO Role
- 2252G: Onsite Visit to the CMHC
- 2252H: Facility Alleges it is Provider-Based
- 2252I: Facility Requests an Alternative Site to be Approved Initially or Subsequent to Approval
- 2252J: RO Approval of CMHC Request for Medicare Approval
- 2252K: RO Denial of CMHC Request for Medicare Approval
- 2252L: Approved Provider Changes Ownership
- 2252L1: Provider Agreement is Assigned, FI Role
- 2252L2: Provider Agreement is Assigned, SA Role
- 2252L3: Provider Agreement is Assigned, RO Role
- 2252L4: Approved Provider Changes Ownership, Provider Agreement Is Not Assigned
- 2252M: Voluntary Termination
- 2252N: Involuntary Termination
- 2252O: Identifying the —"Most Egregious" CMHCs for Termination Action
- 2252P: For Visits to Existing Medicare CMHCs
- Attachment A: Community Mental Health Center Notification and Approval of Address Change
- Attachment B: Community Mental Health Center Site Visit Request Form

IOM – "State Operations Manual," Pub. 100-07, Exhibit 275

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_275.pdf
Exhibit 275, "Attestation Statement," must be completed by CMHCs and returned with a letter requesting participation in the Medicare Program as a CMHC providing partial hospitalization services.

IOM – "State Operations Manual," Pub. 100-07, Exhibit 282

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_282.pdf
Exhibit 282, "Model Letter Participation in Medicare as a Community Mental Health Center Providing Partial Hospitalization Services (Including Threshold and Service Requirements)," is an example of the letter sent by CMS to potential CMHC applicants in which the requirements for becoming a Medicare-certified CMHC are outlined.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following sections which outlines the requirements and procedures for an entity to enroll as a CMHC Medicare provider.

- 15.3: National Provider Identifier (NPI)
- 15.4.1.1: Community Mental Health Centers (CMHCs)

Form – Medicare Enrollment Application – Institutional Providers Form CMS-855A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
A CMHC must complete the Medicare Enrollment Application for Institutional Providers either as the paper Form CMS-855A or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). A CMHC must list in Section 4 all alternative sites where core services are provided (such as proposed alternative sites for an initial applicant and actual alternative sites if the CMHC is already participating in Medicare).

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

Webpage – Survey & Certification – Certification & Compliance – Community Mental Health Centers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CommunityHealthCenters.html
This webpage provides basic information about being certified as a Medicare and/or Medicaid CMHC provider and includes links to applicable laws, regulations, and compliance information. Although a CMHC does not have Conditions of Participation (CoPs), it must provide the core services described in the Public Health Service Act.

Webpage – Survey & Certification – General Information – Policy & Memos to States and Regions

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html
This webpage includes links to all CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices. Use the search feature on this page to find documents pertinent to a CMHC.

COVERAGE

IOM – "Medicare General Information, Eligibility and Entitlement Manual," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," Section 30, "Outpatient Mental Health Treatment Limitation," provides information on the expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," Section 70.3, "Partial Hospitalization Services," details coverage for Partial Hospitalization Programs (PHPs).

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes section 270, "Telehealth Services" which explains telehealth services which may be provided by a CMHC.

Booklet – "Mental Health Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246600.html
This booklet is designed to provide education on mental health services. It includes the following information: covered and non-covered mental health services, eligible professionals, outpatient and inpatient psychiatric hospital services, same day billing guidelines, and National Correct Coding Initiative.

Fact Sheet – "Telehealth Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html
Learn about originating sites; distant site practitioners; telehealth services; and billing and payment for professional services furnished via telehealth and the originating site facility fee.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," provides an overview of billing requirements for Medicare providers and includes CMHC-specific information in the following sections:

- 01: Foreword
- 10.2: FI Jurisdiction of Requests for Payment
- 50.1.2: Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claim Format and Form CMS-1450
- 50.2.3: Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment
- 60.4: Noncovered Charges on Outpatient Bills

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," outlines Medicare billing policies for originating sites for payment of telehealth service, which includes CMHCs, in the following sections:

- 190.2: Eligibility Criteria
- 190.3: List of Medicare Telehealth Services
- 190.6.1: Submission of Telehealth Claims for Distant Site Practitioners
- 190.6.2: Exception for Store and Forward (Noninteractive) Telehealth

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," includes two sections with information specific to a CMHC when completing the Form CMS-1450 or its electronic equivalent:

- 75.1: Form Locators 1-15
- 75.5: Form Locators 43-65

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes CMHC-specific information about claims processing in the following sections:

- 80.3.2.2: Consistency Edits for Institutional Claims
- 130.1.3: Late Charges
- 140.1: Threshold Edit for Outpatient and Inpatient Part B Claims

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System [OPPS])," includes the following sections with information about payment for partial hospitalization services provided by a CMHC:

- 10.1: Background
- 10.7.1: Outlier Adjustments
- 10.7.2.1: Identifying Hospitals and CMHCs Subject to Outlier Reconciliation
- 10.11: Calculation of Overall Cost-to-Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS
- 10.11.1: Requirement to Calculate CCRs for Hospitals Paid Under OPPS and for CMHCs
- 10.11.3.2: Hospital or CMHC Request for Use of a Different CCR
- 10.11.9: Methodology for Calculation of CCR for CMHCs
- 10.11.11: Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs
- 170: Hospital and CMHC Reporting Requirements for Services Performed on the Same Day
- 260: Outpatient Partial Hospitalization Services
- 260.1: Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
- 260.2: Professional Services Related to Partial Hospitalization
- 260.3: Outpatient Mental Health Treatment Limitation for Partial Hospitalization Services
- 260.4: Reporting Service Units for Partial Hospitalization
- 260.5: Line Item Date of Service Reporting for Partial Hospitalization
- 260.6: Payment for Partial Hospitalization Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," outlines Medicare payment policies for originating sites for payment of telehealth service, which includes CMHCs, in the following sections:

- 190.1: Background
- 190.4: Conditions of Payment

- 190.5: Originating Site Facility Fee Payment Methodology
- 190.6: Payment Methodology for Physician/Practitioner at the Distant Site
- 190.7: A/B MAC (B) Editing of Telehealth Claims

Webpage – Hospital Outpatient Prospective Payment System (PPS)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html
This webpage provides information regarding Hospital Outpatient Prospective Payment System Rulemaking, including the CY2016 OPPS/ASC Final Rule including related links to the CY2016 ASC Final Rule addenda and wage index files. The 2016 CMHC outlier threshold and payment percentage can be found in the table depicting 2016 Outlier and Rural Adjustments. To find this information, select Annual Policy Files from the list on the left side of the page, then select the year (2016) from the list in the middle of the page. In the Related Links section, select 2016 Outlier and Rural Adjustments.

Fact Sheet – "Hospital Outpatient Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243664.html
Learn about background; ambulatory payment classifications; how payment rates are set and payment rates; and Hospital Outpatient Quality Reporting Program.

More Resources: Refer to the Hospital pathway for additional information on billing and payment of partial hospitalization services furnished by CMHCs paid through the OPPS.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about CMHCs. Use the search feature on the home page of this website to review these.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Webpage – Limited Data Set (LDS) Files – Hospital Outpatient Prospective Payment System (OPPS) Partial Hospitalization Program LDS

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPSPHPLDS.html
From this page, providers can browse the Record Layout from the Downloads section and obtain instructions for requesting the LDS file. This file contains select claim level data for PHP services. It also includes data elements such as diagnosis codes, bill type, outlier payments, and service revenue payments for PHP services furnished by hospitals and CMHCs paid under the OPPS.

Electronic Mailing List – CMHC-PPS

https://list.nih.gov/cgi-bin/wa.exe?A0=cmhc-pps-l
The CMHC-PPS electronic mailing list is administered by CMS, which emails subscribers information regarding Community Mental Health Center publications, coding, payment, and educational material.

Beneficiary Booklet – "Medicare & Your Mental Health Benefits"

https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf
This booklet explains mental health benefits for beneficiaries with Original Medicare.

Beneficiary Brochure – "Medicare & Your Mental Health Benefits: Getting Started"

https://www.medicare.gov/Pubs/pdf/11358-Medicare-Mental-Health-Getting-Started.pdf
This brochure provides an overview of how Medicare covers inpatient and outpatient mental health services.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Comprehensive Outpatient Rehabilitation Facility Medicare resources.

DEFINITION: COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)

A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician. The CORF must provide the following core CORF services:

- CORF physicians' services
- Physical therapy services
- Social and/or psychological services

CORFs may also provide the following optional services:

- Occupational therapy
- Respiratory therapy
- Speech-language pathology
- Prosthetic/orthotic devices
- Nursing services
- Drugs and biological
- Supplies and Durable Medical Equipment (DME)
- Home Environment Evaluations
- Vaccines
- Lab services

Physical therapy services should comprise a clear majority of the total CORF services provided. The purpose of a CORF is to permit the beneficiary to get multidisciplinary rehabilitation services at a single location in a coordinated fashion.

ENROLLMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 10.1, "Provider Agreements," which references CORFs.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.2, "Comprehensive Outpatient Rehabilitation Facilities (CORFs)," which provides information on CORF enrollment in the Medicare Program.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections which provide information regarding the survey and certification of CORFs:

- 2306: When a Rehabilitation Agency's Extension Location Becomes Its Primary Site
- 2360: CORF – Citations and Description
- 2362: Scope and Site of Services
- 2364: CORF'S Relationship With Other Providers or Suppliers
- 2364A: Shared Space With Another Provider or Supplier
- 2364B: Sharing of Equipment
- 2364C: Employee Sharing
- 2366: Conversion of OPT/OSP to CORF

IOM – "State Operations Manual," Pub. 100-07, Appendix K

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_k_corf.pdf
Appendix K, "Guidance to Surveyors: Comprehensive Outpatient Rehabilitation Facilities," includes State survey information for CORFs.

Webpage – Survey & Certification – Certification & Compliance – Comprehensive Outpatient Rehabilitation Facilities

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CORFs.html
This webpage provides basic information about being certified as a Medicare CORF provider and includes helpful links.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participation (CoPs) – Comprehensive Outpatient Rehabilitation Facilities (CORFs)

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/CORFs.html
This webpage provides links to important resources regarding CfCs and CoPs for CORFs.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Comprehensive Outpatient Rehabilitation Facilities

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/CORF.html
This webpage explains that survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of survey findings.

This webpage provides a link to Appendix K of the "State Operations Manual" and to the Certification and Compliance for CORFs webpage.

Form – Instructions for Completing the Comprehensive Outpatient Rehabilitation Facility Request for Certification to Participate in the Medicare Program Form CMS-359

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms359.pdf
Filing this request for certification to the State will initiate the process of obtaining a decision as to whether the Conditions of Participation are (continue to be) met.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c12.pdf
Chapter 12, "Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage," has the following sections about CORF coverage:

- 10: Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare
- 20.1: Required Services
- 20.2: Optional CORF Services
- 30: Rules for Provision of Services
- 40.1: Physicians' Services
- 40.2: Physical Therapy Services
- 40.3: Occupational Therapy Services
- 40.4: Speech-Language Pathology Services
- 40.5: Respiratory Therapy Services
- 40.6: Prosthetic and Orthotic Devices and Supplies
- 40.7: Social and/or Psychological Services
- 40.8: Nursing Services
- 40.9: Drugs and Biologicals
- 40.10: Home Environment Evaluation
- 40.11: Vaccines

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to physical and occupational therapy and speech-language pathology in specific NCDs. Applicable NCDs may be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Administrative Contractors.

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf

- 160.12: Neuromuscular Electrical Stimulator (NMES)

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

Fact Sheet – "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243510.html
This fact sheet is designed to provide education on Medicare coverage and billing requirements for power mobility devices (PMDs). It includes information concerning basic coverage criteria and documentation requirements as well as, detailed coverage guidelines for the specific type of PMD provided.

Form – Plan of Treatment for Outpatient Rehabilitation Form CMS-700

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS700.pdf
This form may be used to establish an outpatient rehabilitation plan of treatment.

Form – Updated Plan of Progress for Outpatient Rehabilitation Form CMS-701

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS701.pdf
This form may be used to update the outpatient rehabilitation plan of treatment.

BILLING

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about CORF billing:

- 20.1: Discipline Specific Outpatient Rehabilitation Modifiers – All Claims
- 20.2: Reporting of Service Units With HCPCS
- 20.3: Determining What Time Counts Towards 15-Minute Timed Codes – All Claims
- 20.4: Coding Guidance for Certain CPT Codes – All Claims
- 20.5: CORF/OPT Edit for Billing Inappropriate Supplies
- 40: Special Claims Processing Rules for Institutional Outpatient Rehabilitation Claims
- 40.2: Applicable Types of Bill
- 40.3: Applicable Revenue Codes
- 40.4: Edit Requirements for Revenue Codes
- 40.5: Line Item Date of Service Reporting
- 40.6: Non-covered Charge Reporting
- 50: CWF and PS&R Requirements – A/B MAC (A)
- 100.1.1: Allowable Revenue Codes on CORF 75X Bill Types
- 100.8: Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings
- 100.10: Group Therapy Services (Code 97150)
- 100.10.1: Therapy Students
- 100.11: Billing for Social Work and Psychological Services in a CORF
- 100.12: Billing for Respiratory Therapy Services in a CORF

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Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
This page provides helpful information on therapy payment caps.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

MLN Matters® Article – MM9448 "Therapy Cap Values for Calendar Year (CY) 2016"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9448.pdf
This MLN Matters® article describes the CMS policy for outpatient therapy caps for CY 2016.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c12.pdf
Chapter 12, "Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage," includes Section 30.1, "Rules for Payment of CORF Services."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about CORF claims processing and payment:

- 10: Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General
- 10.1: New Payment Requirement for Intermediaries (FIs)
- 10.2: The Financial Limitation Legislation
- 10.3: Application of Financial Limitations
- 10.4: Claims Processing Requirements for Financial Limitations
- 10.5: Notification for Beneficiaries Exceeding Financial Limitations
- 10.6: Functional Reporting
- 10.7: Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services
- 40.1: Determining Payment Amounts – Institutional Claims
- 50: CWF and PS&R Requirements – A/B MAC (A)
- 100.2: Obtaining Fee Schedule Amounts
- 100.6: Notifying Patient of Service Denial
- 100.7: Payment of Drugs, Biologicals, and Supplies in a CORF
- 100.8: Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

Paper-Based Manual – "The Provider Reimbursement Manual – Part 1," Pub. 15-1, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 14, "Reasonable Cost of Therapy and Other Services," includes information relevant to CORFs.

Paper-Based Manual – "The Provider Reimbursement Manual – Part 2," Pub. 15-2, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 6, "CORF's FORM HCFA-2088," provides information about the Form CMS-2088. This report provides for the determination of allowable outpatient physical therapy and outpatient speech-language pathology costs.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI, "Medicine, Evaluation and Management Services (CPT Codes 90000-99999)," includes coding information relevant to services performed by an occupational or physical therapist. In addition, CORFs should click on the National Correct Coding Initiative (NCCI) Coding Edits to search for applicable NCCI edits.

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Webpage – Medical Review and Education – Therapy Cap

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exception process through December 31, 2017 and modified the requirement for manual medical review for services over the $3,700 therapy thresholds. MACRA eliminated the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process. MACRA also prohibits the use of Recovery.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Section 150.3, "Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations," includes information on expedited determinations.

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs) (collectively referred to as Medicare Health Plans)," includes several references to CORFs in regards to Medicare Advantage (MA) Plans including Quality Improvement Organizations (QIOs) fast track reviews.

Webpage – Beneficiary Notices Initiative (BNI)

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html
This webpage explains that CORFs are required to provide a Generic Notice to beneficiaries to alert them that Medicare covered item(s) and/or service(s) are ending and give beneficiaries the opportunity to request an expedited determination from a QIO. A Detailed Notice is given when the QIO review is requested to provide more explanation on why coverage is ending.

Webpage – Beneficiary Notices Initiative (BNI) – FFS ED Notices

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
This webpage explains CORF use of the expedited notices, Forms CMS-10123 and CMS-10124, and provides links to these notices in English and Spanish.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about CORFs. Use the search feature on the home page of this website to review these.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Occupational therapy services, physical therapy services, and outpatient speech-language pathology services are considered DHS.

Electronic Mailing List – Other-Prospective Payment System (PPS)

https://list.nih.gov/cgi-bin/wa.exe?A0=other-pps-l
The CORF electronic mailing list is administered by CMS, which emails subscribers information regarding CORF policy, publications, coding, payment, and educational material.

END STAGE RENAL DISEASE FACILITY

INTRODUCTION

This curriculum is designed as a pathway to End Stage Renal Disease Facility Medicare resources.

DEFINITION: END STAGE RENAL DISEASE (ESRD) FACILITY

An ESRD facility is a facility which is approved to furnish at least one specific ESRD service. Such facilities are:

- Renal Transplantation Center – A hospital unit that is approved to furnish transplantation and other medical and surgical specialty services required for the care of the ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement. A renal transplantation center may also be a renal dialysis center.
- Renal Dialysis Center – A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients (including inpatient dialysis furnished directly or under arrangement). A hospital need not provide renal transplantation to qualify as a renal dialysis center.
- Renal Dialysis Facility – An independent unit that is approved to furnish dialysis service(s) directly to ESRD patients.
- Self-Dialysis Unit – A unit that is part of an approved renal transplantation center, renal dialysis center, or renal dialysis facility, and furnishes self-dialysis services.
- Special Purpose Renal Dialysis Facility – A renal dialysis facility that is approved to furnish dialysis at special locations on a short-term basis to a group of dialysis patients otherwise unable to obtain treatment in the geographical area. The special locations must be either special rehabilitative (including vacation) locations serving ESRD patients temporarily residing there or locations in need of ESRD facilities under emergency circumstances.

Webpage – End Stage Renal Disease (ESRD) Center

https://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html
The ESRD Center contains helpful links to billing/payment, forms, coverage, enrollment and certification, Centers for Medicare & Medicaid Services (CMS) resources, and quality initiative and demonstrations.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.3, "End-Stage Renal Disease Facilities (ESRDs)," which describes the types of ESRD facilities as well as the enrollment, survey, certification, and policies required of ESRD facilities.

Form – Medicare Enrollment Application – Institutional Providers Form CMS-855A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
ESRD facilities must complete the Medicare Enrollment Application for Institutional Providers, Form CMS-855A, either as a paper form or through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Providers must submit separate enrollment applications if the types of providers for which this application is being submitted are separately recognized provider types with different rules regarding Medicare participation. For example, if a provider functions as both a hospital and an ESRD facility, the provider must complete two separate enrollment applications, one for the hospital and one for the ESRD facility.

Refer to the Laboratory, Hospital, and Transplant Hospital pathways for further, related information.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," describes the steps a facility must go through to be certified as meeting the requirements for an ESRD facility. The following sections are specific to ESRD facilities:

- 2270: ESRD Citations
- 2272A: Renal Transplantation Center
- 2272B: Renal Dialysis Center
- 2272C: Renal Dialysis Facility
- 2272D: Self-Dialysis Unit
- 2274: ESRD Application Requirement
- 2276: SA Control of Form CMS-3427
- 2278A: Facility Withdraws Application Prior to Survey
- 2278B: Conducting SA Survey
- 2278C: Certificate of Need (CON)
- 2278D: Initial RO Approval
- 2278E: Expansion or Addition of Services – RO Procedures
- 2278F: RO Recertification
- 2278G: Invalid Application
- 2280: RO Facility Classification (42 CFR 405.2122)
- 2280A: Renal Transplantation Center (RTC)
- 2280B: Renal Dialysis Center (RDC)
- 2280C: Renal Dialysis Facility (RDF)
- 2280D: Special Purpose Renal Dialysis Facility (SPRDF)
- 2280.1: Provider Status: Renal Transplantation Center and Renal Dialysis Center (42 CFR 405.2131)
- 2280.2: Furnishing Data and Information for ESRD Program Administration (42 CFR 405.2133)
- 2280.3: Participation In Network Activities (42 CFR 405.2134)
- 2280.4: Minimal Laboratory Service Requirements for a Renal Dialysis Facility or a Renal Dialysis Center (42 CFR 405.2163(b)) and a Renal Transplantation Center (42 CFR 405.2171(d))
- 2281: Participation of Veterans Administration (VA) Hospitals in the ESRD Program
- 2281A: Survey Responsibility
- 2281B: Special Survey Interpretations
- 2281C: Designated Intermediary/Carrier
- 2282: RO Use of Provider Tie-In Notice, Form CMS-2007, for Suppliers of ESRD Program Services (Exhibit 156)
- 2283: Change of Ownership of Hospital-Located Outpatient Renal Dialysis Facilities (From Hospital to Nonhospital) – RO Procedures
- 2285: Alternative Sanctions for Failure to Participate in Network Activities
- 2285.1: Identification of Facilities That Fail to Participate in Network Activities
- 2285.2: Imposition of the Sanction
- 2285.3: Duration and Removal of the Sanction
- 2285.4: Notice and Appeal Rights
- 2286: Continuous Ambulatory Peritoneal Dialysis Coverage (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD)
- 2286A: How CAPD is Performed

- 2286B: Application and Determination Procedure
- 2287: Classification of Maintenance Dialysis Facilities as Hospital-Based or Independent: Prospective Payment
- 2287A: Hospital-Based ESRD Facility
- 2287B: Independent ESRD Facility
- 2779A: Numbering System for CMS Certification Numbers
- 2779A1: CMS Certification Numbers for Providers
- 2779A2: CMS Certification Numbers for Suppliers
- 2779J: ESRD CMS Certification Numbers

IOM – "State Operations Manual," Pub. 100-07, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf
Chapter 3, "Additional Program Activities," includes the following sections related to ESRD certification:
- 3206: Existing ESRD Facility Relocation, Expansion, or Addition of New Service
- 3220B: Services Not In Compliance (HHAs, RHCs, and ESRD Facilities)

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – End-Stage Renal Disease Facilities

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/ESRD.html
This webpage provides downloads of the "State Operations Manual" and "ESRD Conditions Final Rule," as well as links to several helpful resources. The ESRD CfCs are the minimum health and safety rules that all Medicare and Medicaid participating dialysis facilities must meet.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Dialysis

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html
This webpage provides basic information related to survey and certification of dialysis facilities for ESRD surveyors and dialysis providers. It provides resources to support and assess compliance with Federal regulations.

Document – "Emergency Preparedness for Dialysis Facilities – A Guide for Chronic Dialysis Facilities"

https://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDNetworkOrganizations/downloads/EmergencyPreparednessforFacilities2.pdf
This document provides guidance to dialysis facilities for emergency management procedures.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c02.pdf
Chapter 2, "Hospital Insurance and Supplementary Medical Insurance," includes the following sections related to ESRD coverage:
- 10.4: Hospital Insurance for Persons Needing Kidney Transplant or Dialysis
- 10.4.1: Effective Date of Entitlement for Persons on Dialysis
- 10.4.2: Entitlement Based on Transplant
- 10.4.3: Effect on Self-dialysis Training on Entitlement
- 10.4.4: End of Coverage Based on ESRD
- 10.4.5: Reentitlement for Beneficiaries with ESRD
- 30: End of Coverage for Hospital Insurance
- 40.3: Enrollment Periods
- 40.7.1: Amount of Premiums
- 40.7.2: Increase in Base Premium Amount

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 10, "Covered Inpatient Hospital Services Covered Under Part A," which provides coverage information for dialysis provided to beneficiaries in an inpatient hospital stay.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
Chapter 7, "Home Health Services," includes Section 80.5, "Services Covered Under the End Stage Renal Disease (ESRD) Program," which discusses dialysis services provided to beneficiaries under a home health plan of care.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
Chapter 11, "End Stage Renal Disease (ESRD)," contains the following sections relating to ESRD coverage:

- 10: Definitions Relating to ESRD
- 20: Renal Dialysis Items and Services
- 20.1: Composite Rate Items and Services
- 20.2: Laboratory Services
- 20.3: Drugs and Biologicals
- 20.4: Equipment and Supplies
- 30: Home Dialysis
- 30.1: Home Dialysis Items and Services
- 30.2: Home Dialysis Training
- 40: Other Services
- 50: ESRD Prospective Payment System (PPS) Base Rate
- Appendix A: Composite Rate Tests for Hemodialysis, IPD, CCPD, and Hemofiltration
- Appendix B: Appendix B/Composite Rate Tests for CAPD
- 140: Transplantation
- 140.1: Identifying Candidates for Transplantation
- 140.2: Identifying Suitable Live Donors
- 140.3: Pretransplant Outpatient Services
- 140.4: Pretransplant Inpatient Services
- 140.5: Living Donor Evaluation, Patient Has Entitlement or is in Preentitlement Period
- 140.6: Kidney Recipient Admitted for Transplant Evaluation
- 140.7: Kidney Recipient Evaluated for Transplant During Inpatient Stay
- 140.8: Kidney Recipient Admitted for Transplantation and Evaluation
- 140.9: Post-transplant Services Provided to Live Donor
- 140.10: Coverage After Recipient Has Exhausted Part A
- 140.11: Cadaver Kidneys
- 140.12: Services Involved
- 140.13: Tissue Typing Services for Cadaver Kidney
- 140.16: Noncovered Transplant Related Items and Services
- 140.17: Other Covered Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to ESRD coverage:

- 30: Physician Services
- 50.5.2: Erythropoietin (EPO)
- 50.5.2.1: Requirements for Medicare Coverage for EPO
- 310: Kidney Disease Patient Education Services

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to ESRD in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Administrative Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 20.3: Thoracic Duct Drainage (TDD) in Renal Transplants
- 20.7: Percutaneous Transluminal Angioplasty (PTA)

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf

- 110.10: Intravenous Iron Therapy
- 110.15: Ultrafiltration, Hemoperfusion and Hemofiltration

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf

- 190.10: Laboratory Tests - CRD Patients
- 190.15: Blood Counts
- 190.17: Prothrombin Time (PT)
- 190.18: Serum Iron Studies

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 230.7: Water Purification and Softening Systems Used in Conjunction With Home Dialysis
- 230.13: Peridex CAPD Filter Set
- 230.14: Ultrafiltration Monitor
- 230.19: Levocarnitine for Use in the Treatment of Carnitine Deficiency in ESRD Patients

IOM – "Medicare Secondary Payer (MSP) Manual," Pub. 100-05, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c02.pdf
Chapter 2, "MSP Provisions," includes the following sections related to ESRD Services:

- 20: Medicare Secondary Payer Provisions for End-Stage Renal Disease (ESRD) Beneficiaries
- 20.1: Determining the 30 Month Coordination Period During Which Medicare May Be Secondary Payer
- 20.1.1: Duration of Coordination Period
- 20.1.2: Determination for Subsequent Periods of ESRD Eligibility
- 20.1.3: Dual Eligibility/Entitlement Situations
- 20.2: Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA)

Podcast – "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2012-09-13-Renal-UT-Disorders.html
This podcast is designed to provide education on CMS Recovery Audit findings from medical necessity reviews of renal and urinary tract disorders. It includes information from MLN Matters® Article SE1210, titled "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders."

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following information specific to ESRD facilities:

- 10.1: Carrier Jurisdiction of Requests for Payment
- 10.1.1: Payment Jurisdictions Among A/B MAC's (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services
- 20: Provider Assignment to FIs and MACs
- 30.3.1: Mandatory Assignment on Carrier Claims
- 30.3.8: Mandatory Assignment and Other Requirements for Home Dialysis Supplies and Equipment Paid Under Method II on Claims Submitted to Carriers
- 50.2.2: Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services
- 80.3.2.2: Consistency Edits for Institutional Claims
- 100: Medicare as a Secondary Payer
- 130.1.3: Late Charges
- 140.1: Threshold Edit for Outpatient and Inpatient Part B Claims
- 160.1: Reporting of Taxonomy Codes (Institutional Providers)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections related to ESRD billing:

- 40.3: Outpatient Services Treated as Inpatient Services
- 50.3: Late Charges
- 70.1: Providers Using All-Inclusive Rates for Inpatient Part A Charges
- 90.1: Kidney Transplant – General
- 90.1.2: Billing for Kidney Transplant and Acquisition Services
- 90.1.3: Billing for Donor Post-Kidney Transplant Complication Services
- 100.6: Inpatient Renal Services
- 170.2.2: Required Data Elements on Claims for RNHCI Services
- Addendum A: Provider Specific File

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes the following sections specific to hospital-based and independent ESRD billing:

- 10.1: Background
- 20.1: General
- 120.2: Routing of Claims
- 200.2: Hospital Dialysis Services For Patients With and Without End Stage Renal Disease (ESRD)

- 300: Medical Nutrition Therapy (MNT) Services
- 300.1: General Conditions and Limitations on Coverage

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
Chapter 6, "SNF Inpatient Part A Billing and SNF Consolidated Billing," includes the following sections related to ESRD services:

- 10.1: Consolidated Billing Requirement for SNFs
- 20.1.2: Other Excluded Services Beyond the Scope of a SNF Part A Benefit
- 20.2: Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election
- 20.2.1: Dialysis and Dialysis Related Services to a Beneficiary With ESRD
- 20.2.1.1: ESRD Services
- 20.2.1.2: Coding Applicable to Dialysis Services Provided in a Renal Dialysis Facility (RDF) or Home
- 20.3.1: Ambulance Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 8

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf
Chapter 8, "Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims," contains the following sections which are pertinent to ESRD billing:

- 50: In-Facility Dialysis Bill Processing Procedures
- 50.1: Laboratory Services Included in the Composite Rate
- 50.1.5: Lab Services Included in the Prospective Payment System
- 50.2: Drugs and Biologicals Included in the Composite Rate
- 50.2.5: Drugs and Biologicals Included in the PPS
- 50.3: Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS
- 50.3.1: Submitting Corrected Bills
- 50.4: Line Item Detail Billing and Automated Claim Adjustments
- 50.5: IPD in the Facility
- 50.6: In-Facility Back-Up Dialysis
- 50.6.1: Payment for In-Facility Maintenance Dialysis Sessions Furnished to CAPD/CCPD Home Dialysis Patients
- 50.6.2: Payment for Hemodialysis Sessions
- 50.7: Ultrafiltration
- 50.8: Training and Retraining
- 50.9: Coding for Adequacy of Dialysis, Vascular Access and Infection
- 60: Separately Billable ESRD Items and Services
- 60.1: Lab Services
- 60.2: Drugs Furnished in Dialysis Facilities
- 60.2.1: Billing Procedures for Drugs for Facilities
- 60.2.1.1: Separately Billable ESRD Drugs
- 60.2.1.2: Facilities Billing for ESRD Oral Drugs as Injectable Drug Equivalents
- 60.2.2: Drug Payment Amounts for Facilities
- 60.2.3: Use of Additional Codes by Facilities to Report Drugs
- 60.2.4: Intravenous Iron Therapy
- 60.2.4.1: Facility Billing Requirements to the A/B MAC (A)
- 60.2.4.2: Physician Billing Requirements to the A/B MAC (B)
- 60.3: Blood and Blood Services Furnished in Hospital Based and Independent Dialysis Facilities
- 60.4: Erythropoietin Stimulating Agents (ESAs)
- 60.4.1: ESA Claims Monitoring Policy
- 60.4.2: Facility Billing Requirements for ESAs
- 60.4.2.1: Other Information Required on the Form CMS-1500 for Epoetin Alfa (EPO)

- 60.4.2.2: Completion of Subsequent Form CMS-1500 Claims for Epoetin Alfa (EPO)
- 60.4.3: Epoetin Alfa (EPO) Supplier Billing Requirements (Method II) on the Form CMS-1500
- 60.4.3.1: Other Information Required on the Form CMS-1500 for Epoetin Alfa (EPO)
- 60.4.3.2: Completion of Subsequent Form CMS-1500 Claims for Epoetin Alfa (EPO)
- 60.4.4: Payment Amount for Epoetin Alfa (EPO)
- 60.4.4.1: Payment for Epoetin Alfa (EPO) in Other Settings
- 60.4.4.2: Epoetin Alfa (EPO) Provided in the Hospital Outpatient Departments
- 60.4.5: ESAs Furnished to Home Patients
- 60.4.5.1: Self Administered ESA Supply
- 60.4.6: Darbepoetin Alfa (Aranesp) Supplier Billing Requirements (Method II) on the Form CMS-1500 and Electronic Equivalent
- 60.4.6.1: Other Information Required on the Form CMS-1500 for Darbepoetin Alfa (Aranesp)
- 60.4.6.2: Completion of Subsequent Form CMS-1500 Claims for Darbepoetin Alfa (Aranesp)
- 60.4.6.3: Payment Amount for Darbepoetin Alfa (Aranesp)
- 60.4.6.4: Payment for Darbepoetin Alfa (Aranesp) in Other Settings
- 60.4.6.5: Payment for Darbepoetin Alfa (Aranesp) in the Hospital Outpatient Department
- 60.5: Intradialytic Parenteral/Enteral Nutrition (IDPN)
- 60.6: Vaccines Furnished to ESRD Patients
- 60.8: Shared Systems Changes for Medicare Part B Drugs for ESRD Independent Dialysis Facilities
- 80: Home Dialysis Method I Billing to the A/B MAC (A)
- 80.1: Items and Services Included in the Composite Rate for Home Dialysis
- 80.2: General A/B MAC (A) Bill Processing Procedures for Method I Home Dialysis Services
- 80.2.1: Required Billing Information for Method I Claims
- 80.3: Calculating Payment for Intermittent Peritoneal Dialysis (IPD) for Method I Claims Submitted to the A/B MAC (A)
- 80.3.1: IPD at Home for Method I Claims Submitted to the A/B MAC (A)
- 80.4: Calculating Payment for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) Under the Composite Rate
- 90: Method II Billing
- 90.1: DME MAC Denials for Beneficiary Submitted Claims Under Method II
- 90.2: Requirements for Payment by the DME MAC
- 90.2.1: Supplier Documentation Required
- 90.2.2: DME MAC Letter Explaining Requirements to Method II Supplier
- 90.3: Amount of Payment by the DME MAC
- 90.3.1: Billing Instructions for Method II to DME MACs
- 90.3.2: Home Dialysis Supplies and Equipment HCPCS Codes Used to Bill the DME MAC
- 90.3.3: DME MAC Claims Processing Instructions
- 90.4: Equipment and Equipment Related Services Provided to Direct Dealing Beneficiary
- 90.5: Method II Support Services Billed to the A/B MAC (A) by the Facility
- 90.5.1: Billable Revenue Codes Under Method II
- 90.5.1.1: Unbillable Revenue Codes Under Method II
- 100.1: Traveling Patients Who Are Normally In-Facility Dialysis Patients
- 100.2: Traveling Patients Who are Normally Home Dialysis
- 100.3: Physician's Services Furnished to a Dialysis Patient Away From Home or Usual Facility
- 130: Physicians and Supplier (Nonfacility) Billing for ESRD Services – General
- 130.1: Initial Method for Physician's Services to Maintenance Dialysis Patients
- 170: Billing Physician Dialysis Services (codes 90935 – 90999) and Related Payment

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes:

- 190.3: List of Medicare Telehealth Services
- 190.6.1: Submission of Telehealth Claims for Distant Site Practitioners

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," includes information on ESRD billing:

- 40.6: Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests
- 40.6.1: Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries
- 40.6.2: Claims Processing for Separately Billable Tests for ESRD Beneficiaries
- 40.6.2.1: Separately Billable ESRD Laboratory Tests Furnished by Hospital-Based Facilities
- 40.6.2.3: Skilled Nursing Facility (SNF) Consolidated Billing (CB) Editing and Separately Billed ESRD Laboratory Test Furnished to Patients of Renal Dialysis Facilities
- Exhibit 1: List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Chapter 17, "Drugs and Biologicals," provides information for ESRD facilities including:

- 20.5.8: Injections Furnished to ESRD Beneficiaries
- 80.3: Billing for Immunosuppressive Drugs
- 80.9: Required Modifiers for ESAs Administered to Non-ESRD Patients
- 80.11: Requirements for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes the following sections with information relevant to ESRD facilities:

- 10.2.4.1: Hepatitis B Vaccine Furnished to ESRD Patients
- 120.1: Coding and Payment of DSMT Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
The following sections of Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," are related to ESRD billing:

- 10.1.1: Durable Medical Equipment (DME)
- 20.3: Elimination of "Kit" Codes and Pricing of Replacement Codes
- 100.2.2.2: Completion of the Elements of PEN CMN

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," provides special information for ESRD Facilities regarding Form Locator (FL) 80, Remarks. This information is necessary when completing the paper Form CMS-1450 or its electronic equivalent.

IOM – "Medicare Secondary Payer (MSP) Manual," Pub. 100-05, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf

Chapter 1, "Background and Overview," includes:

- 10.2: End-Stage Renal Disease (ESRD)
- 70.3: Differentiation for ESRD

IOM – "Medicare Secondary Payer (MSP) Manual," Pub. 100-05, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf
Chapter 3, "MSP Provider, Physician, and Other Supplier Billing Requirements," includes the following sections related to ESRD billing:

- 10.2: Situations in Which MSP Billing Applies
- 20.1: General Policy
- 40.1.2: Outpatient Bills, Part B Inpatient Services, and HHA Bills
- 40.2.1: Partial Payment by Primary Payer for Inpatient Services, Outpatient Services, Part B Inpatient Services, and HHA Bills
- 40.3: Annotation of Claims Denied by GHPs, Liability or No-Fault Insurers
- 50: Summary of MSP Data Elements for Form CMS-1450 (UB-92)

IOM – "Medicare Secondary Payer (MSP) Manual," Pub. 100-05, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c05.pdf
Chapter 5, "Contractor Prepayment Processing Requirements," contains the following sections related to ESRD billing:

- 30.3.2: Develop ESRD Claims Where Basis for Medicare Entitlement Changes
- 40.6.1: Conditional Medicare Payment
- 70.3.1.5: ESRD Bills

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
Chapter 11, "End Stage Renal Disease (ESRD)," contains the following sections relating to ESRD payment:

- 10: Definitions Relating to ESRD
- 20: Renal Dialysis Items and Services
- 20.1: Composite Rate Items and Services
- 20.2: Laboratory Services
- 20.3: Drugs and Biologicals
- 20.4: Equipment and Supplies
- 30: Home Dialysis
- 30.1: Home Dialysis Items and Services
- 30.2: Home Dialysis Training
- 40: Other Services
- 50: ESRD Prospective Payment System (PPS) Base Rate
- 60: ESRD PPS Case-Miix Adjustments
- 70: ESRD PPS Transition Period
- 80: Bad Debts
- 90: Medicare as a Secondary Payer
- Appendix B: Appendix B/Composite Rate Tests for CAPD
- Appendix C: Appendix C/Brief History of ESRD Compostie Payment Rates for Outpatient Maintenance Dialysis
- 140: Transplantation
- 140.11: Cadaver Kidneys
- 140.12: Services Involved
- 140.13: Tissue Typing Services for Cadaver Kidney

- 140.14: Cadaver Excision Yielding Two Kidneys
- 140.15: Provider Costs Related to Cadaver Kidney Excisions

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections related to ESRD payment:
- 270.4.1: Payment for ESRD-Related Services as a Telehealth Service
- 270.5.1: Originating Site Facility Fee Payment (ESRD-Related Services)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections related to ESRD payment:
- 90.1: Kidney Transplant – General
- 90.1.1: The Standard Kidney Acquisition Charge
- 90.1.2: Billing for Kidney Transplant and Acquisition Services
- 90.1.3: Billing for Donor Post-Kidney Transplant Complication Services

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 8

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf
Chapter 8, "Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims," contains the following sections which are pertinent to both the basic case-mix adjusted composite payment system and the Prospective Payment System (PPS):
- 10: General Description of ESRD Payment and Consolidated Billing Requirements
- 10.1: General Description of ESRD Facility Composite Rates
- 10.2: Uncompleted Treatments
- 10.3: No-Shows
- 10.4: Deductible and Coinsurance
- 10.5: Hospital Services
- 10.6: Amount of Payment
- 10.7: ESRD Services Not Provided Within the United States
- 10.8: Transportation Services
- 10.9: Dialysis Provider Number Series
- 20: Definitions Related to Calculating the Composite Rate and the ESRD Prospective Payment System Rate
- 20.1: Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate
- 20.1.1: Calculation for Double Amputee Dialysis Patients
- 30.1: Publication of Composite Rates
- 30.2: Determining Individual Facility Composite Rate
- 30.3: Transition Period
- 30.4: Record-Keeping and Reporting Requirements Under Composite Rate System
- 30.5: Facility Preparation and A/B MAC (A) Review of Cost Reports
- 30.6: Issuance of Notice of Program Reimbursement
- 40: Processing Requests for Composite Rate Exceptions
- 40.1: General Instructions for Processing Exceptions Under the Composite Rate Reimbursement System
- 40.2: Criteria for Approval of ESRD Exception Requests
- 40.3: Procedures for Requesting Exceptions to ESRD Payment Rates
- 40.4: Period of Approval: Payment Exception Requests
- 40.5: Criteria for Refiling a Denied Exception Request
- 40.6: Responsibility of Intermediaries
- 40.7: Payment Exception: Pediatric Patient Mix
- 40.8: Payment Exception: Self-Dialysis Training Costs in Pediatric Facilities

- 40.85: Pediatric Payment Model for ESRD PPS
- 50.1.5: Lab Services Included in the Prospective Payment System
- 50.2.5: Drugs and Biologicals Included in the PPS
- 70: Payment for Home Dialysis
- 70.1: Method Selection for Home Dialysis Payment
- 70.1.1: Change in Method
- 70.2: Prevention of Double Billing Under Method I and II
- 70.3: Overpayments
- 110: Reduction in Medicare Program Payment to Fund ESRD Networks
- 120: Renal Transplantation and Related Services
- 120.1: Payment for Immunosuppressive Drugs Furnished to Transplant Patients
- 140: Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis
- 140.1: Payment for ESRD–Related Services Under the Monthly Capitation Payment (Center Based Patients)
- 140.1.1: Payment for Managing Patients on Home Dialysis
- 140.1.2: Patients That Switch Modalities (Center to Home and Vice Versa)
- 140.2: Payment for ESRD-Related Services (Per Diem)
- 140.2.1: Guidelines for Physician or Practitioner Billing (Per Diem)
- 140.3: Data Elements Required on Claim for Monthly Capitation Payment
- 140.4: Controlling Claims Paid Under the Monthly Capitation Payment Method
- 150: Physician's Self-Dialysis Training Services
- 160: Payment for Physician's Services Furnished to Dialysis Inpatients
- 160.1: Determining Whether Physician Services Furnished on Day of Dialysis
- 160.2: Physicians' Services Furnished on Day of Dialysis
- 160.3: Physicians' Services Furnished on Non-Dialysis Days
- 160.4: Requirements for Payment
- 180: Noninvasive Studies for ESRD Patients – Facility and Physician Services
- 190: Appeal Rights for Denied Claims
- 200: Utilization of REMIS for A/B MAC (B) Claims Adjudication

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Chapter 12, "Physicians/Nonphysician Practitioners," includes Section 90.2.1, "Inpatient Hospital Visits With Dialysis Patients."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Chapter 17, "Drugs and Biologicals," provides information for ESRD facilities including:

- 10: Payment Rules for Drugs and Biologicals
- 20.1.2: Average Sales Price (ASP) Methodology

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
The following sections of Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," are related to ESRD payment:

- 30.8.2: Installation and Delivery Charges for ESRD Equipment
- 40.1: General
- 40.2: Maintenance and Service of Capped Rental Items

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 27

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 27, "ESRD Services and Supplies," contains payment information for providers on Outpatient Maintenance Dialysis Services, including Composite Rate Payment for In-Facility and Home Dialysis.

Paper-Based Manual – "The Provider Reimbursement Manual-Part 2," Pub. 15-2, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 9, "Independent Renal Dialysis Facility HCFA 265," contains instructions to providers for completing the Independent Renal Dialysis Facility Cost Report Form HCFA-265.

Paper-Based Manual – "The Provider Reimbursement Manual-Part 2," Pub. 15-2, Chapters 28, 34, and 36

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 28, "Hospital Cost Reporting (Form HCFA-2552-92 Instructions & Specifications)" includes Supplemental Worksheet E-3 - Calculation of Reimbursement Settlement Part IV, "Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs," which provides specific guidance to ESRD providers in completing Form HCFA-2252-92. Chapter 34, "Indep RDF (Instructions)," provides information on the independent renal dialysis facility cost report Form CMS-265-94, which must be completed by all ESRD facilities which are not hospital-based. Chapter 36, "Hospital and Healthcare Complex (Form CMS-2552-96)," provides guidance for completing Hospital and Hospital Health Care Complex Cost Report Form CMS 2252-96, which is required of all hospital-based Medicare ESRD providers.

Webpage – ESRD Payment – ESRD Prospective Payment System (PPS) Overview

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html
This webpage describes the composite payment system for ESRD services, as well as the PPS system and provides links to valuable information.

Webpage – ESRD Payment – End-Stage Renal Disease (ESRD) Payment Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html
This webpage lists proposed and final regulations and notices about payment to ESRD facilities for outpatient maintenance dialysis. From this webpage, providers can download the current calendar year's changes to ESRD payment policy.

Webpage – ESRD Payment – Educational Resources

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/educational_resources.html
This webpage provides educational information and resources that have been developed for the ESRD provider community.

Webpage – ESRD Payment – ESRD Consolidated Billing

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html
This webpage includes two PDF documents titled "Items and Services Subject to Consolidated Billing for the ESRD PPS Effective 1-1-2012" and "Items and Services Subject to Consolidated Billing for the ESRD PPS Effective 10-1-2012." The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and are no longer separately payable when provided for ESRD beneficiaries by providers other than the ESRD facility.

Webpage – ESRD Payment – ESRD PPS Outlier Services

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html
This webpage contains information about Outlier Services and Portable Document Format (PDF) documents detailing the services and codes included in the program. The outlier payment policy is designed to protect an ESRD facility from significant financial losses due to unusually high costs.

Webpage – ESRD Payment – ESRD Co-morbidity Conditions

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html
This webpage contains information about Comorbidity Conditions recognized in the ESRD PPS and PDF documents detailing the categories and diagnostic codes included. The comorbidity adjustment recognizes the increased costs associated with comorbidities by providing additional payments for certain conditions that occur concurrently with the need for dialysis.

Fact Sheet – "End-Stage Renal Disease Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243661.html
This fact sheet is designed to provide education on the End-Stage Renal Disease Prospective Payment System. It includes the following information: background, transition period, payment rates for adult and pediatric patients, outlier adjustments, home dialysis, laboratory services and drugs and biologicals, patient deductible and coinsurance, and End-Stage Renal Disease Quality Incentive Program.

MLN Matters® Article – MM9367 "Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for Calendar Year (CY) 2016"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9367.pdf
This MLN Matters® article provides information about the CY2016 rate updates for the ESRD PPS.

QUALITY

IOM – "Medicare ESRD Network Organizations Manual," Pub. 100-14, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/eno114c5.pdf
Chapter 5, "Quality Improvement," contains information about quality improvement initiatives for ESRD Network Organizations. Refer to the Other Resources section of this pathway for further information about this manual.

Webpage – End-Stage Renal Disease (ESRD) Quality Improvement Initiative

https://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDQualityImproveInit/index.html
This webpage provides information about the ESRD Quality Initiative, which promotes ongoing CMS strategies to improve the quality of care provided to ESRD patients. This initiative supports quality improvement efforts among providers and makes available quality information that will enable beneficiaries to participate in making health care decisions.

Website – QualityNet

https://www.qualitynet.org
Established by CMS, QualityNet provides health care quality improvement news, resources and data reporting tools and applications used by health care providers and others. QualityNet is the only CMS-approved website for secure communications and health care quality data exchange between: Quality Improvement Organizations (QIOs), hospitals, physician offices, nursing homes, ESRD networks and facilities, and data vendors. Click on ESRD in the banner.

Webpage – ESRD Network Organizations

https://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDNetworkOrganizations/index.html
This webpage provides information about the ESRD Networks, which work with consumers and ESRD facilities and other providers of ESRD services to refine care delivery systems to make sure ESRD patients get the right care at the right time. The program's responsibilities include:

- Assuring the effective and efficient administration of benefits
- Improving quality of care for ESRD patients
- Collecting data to measure quality of care
- Providing assistance to ESRD patients and providers
- Evaluating and resolving beneficiary grievances

OTHER RESOURCES

Other helpful, official resources are included in this section.

IOM – "Medicare ESRD Network Organizations Manual," Pub. 100-14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019209.html
This manual describes the requirements and responsibilities of the ESRD network organizations. CMS contracts nationwide with the 18 ESRD Network Organizations geographically located in designated areas. The networks were established for the purposes of assuring effective and efficient administration of the benefits provided under the Social Security Act for individuals with ESRD. The Network Organization is responsible for conducting activities in the areas of quality improvement, community information and resources, administration, and information management.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term ESRD for related questions and answers. For example, FAQ3451 addresses IV antibiotics administered to an ESRD patient.

Webpage – ESRD PPS Facility FAQs

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/FAQs.html
This webpage is a direct link to all ESRD FAQs and is organized by topic such as cost reporting, claims processing, drugs, and laboratory testing.

Webpage – End-Stage Renal Disease and Clinical Laboratories Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_ESRD.html
This webpage provides information on opportunities for live dialogue between CMS and ESRD providers.

Electronic Mailing List – ESRD

https://list.nih.gov/cgi-bin/wa.exe?A0=ESRD-L
The ESRD electronic mailing list is administered by CMS, which emails subscribers information regarding ESRD policy, publications, coding, payment, and educational material.

Form – End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration Form CMS-2728

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS2728.pdf
Form CMS-2728 must be completed by the ESRD provider for beneficiaries receiving ESRD services. It should not, however, be completed for those beneficiaries who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, meaning several weeks or months.

Form – End Stage Renal Disease Medical Information System ESRD Facility Survey (Dialysis Units Only) Form CMS-2744A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2744a.pdf
Form CMS-2744A should be completed by ESRD facilities and units.

Form – End Stage Renal Disease Medical Information System ESRD Facility Survey (Transplant Centers Only) Form CMS-2744B

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2744b.pdf
Form CMS-2744B is to be completed by kidney transplant centers only.

Form – ESRD Death Notification End Stage Renal Disease Medical Information System Form CMS-2746-U2

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS2746.pdf
Form CMS-2746 must be completed within 2 weeks of the date of death. If the beneficiary was a dialysis patient, the dialysis facility last responsible for the beneficiary's maintenance dialysis (or home dialysis) must complete this form. If the beneficiary was a transplant patient, the transplant center is responsible for completing this form.

Beneficiary Webpage – Dialysis Facility Compare

https://www.medicare.gov/dialysisfacilitycompare/
This website provides important information and resources for beneficiaries and family members who want to learn more about chronic kidney disease and dialysis, including tools for comparing facilities and deciding where to get dialysis.

Beneficiary Booklet – "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services"

https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf
This booklet has information about Medicare coverage for people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Beneficiary Brochure – "Medicare for Children with End-Stage Renal Disease"

https://www.medicare.gov/Pubs/pdf/11392-Medicare-Children-ESRD.pdf
This brochure has information about Medicare coverage for children with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Beneficiary Brochure – "Medicare's Coverage of Dialysis & Kidney Transplant Benefits"

https://www.medicare.gov/Pubs/pdf/11360-Medicare-Dialysis-Kidney-Transplant.pdf
This brochure explains the basics of Medicare's dialysis and kidney transplant benefits.

HOME HEALTH AGENCY

INTRODUCTION

This curriculum is designed as a pathway to Home Health Agency Medicare resources.

Definition: Home Health Agency (HHA)

An HHA is an entity that provides skilled nursing services and at least one of the following therapeutic services: speech therapy, physical therapy, occupational therapy, home health aide services, and medical social services. The services must be furnished in a place of residence used as the beneficiary's home.

A public or voluntary nonprofit health agency may qualify by furnishing:

- Both skilled nursing and at least one other therapeutic service directly to beneficiaries, or directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

For services under hospital insurance (Part A), the term home health agency does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance (Part B).

Webpage – Home Health Agency (HHA) Center

https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
This webpage provides important links regarding HHA billing/payment, policies/regulations, enrollment, participation, certification, and Outcome and Assessment Information Set (OASIS) data.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections about the structure of an HHA:

- 10.1: Provider Agreements
- 10.4: Term of Agreements
- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement
- 50: Home Health Agency Defined
- 50.1: Subdivisions of Agencies as Home Health Agencies
- 50.2: Arrangements by Home Health Agencies
- 50.3: Arrangements with Parent Agency and Other Entities
- 50.4: Notice of Noncoverage of Services
- 50.5: Rehabilitation Centers

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections relevant to enrollment:

- 20: Provider Assignment to FIs and MACs
- 20.1: FI Service to HHAs and Hospices

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes the following information for HHAs:

- 15.3: National Provider Identifier (NPI)
- 15.4.1.6: Home Health Agencies (HHAs)
- 15.5.2.4: Section 2 of the form CMS-855A
- 15.5.12: Special Requirements for Home Health Agencies (HHAs)
- 15.19.1: Application Fees
- 15.19.2.3: Changes of Information and Ownership
- 15.26: Special Provisions for HHAs
- 15.26.1: HHA Ownership Changes
- 15.26.2: Capitalization

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," has the following sections specific to HHAs:

- 1010: Certification Related Functions of SA
- 1012A: Meaning of Certification
- 1018C: Deemed Providers/Suppliers (Excluding CLIA Laboratories)

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," has the following sections specific to HHAs:

- 2008B: Initial Surveys of HHAs
- 2160B: Defining Medicare Eligible Individual's "Home" for Purposes of Durable Medical Equipment (DME) and Home Health Benefits
- 2162: Defining Hospital for Spell of Illness, DME, and Home Health Benefit Purposes
- 2180: HHA - Citations and Description
- 2180A: Citations
- 2180B: Types of Agencies
- 2180C: General Requirements
- 2180D: Services Provided
- 2180E: Application of Home Health Agency Conditions of Participation to Patients Receiving Chore Services Exclusively
- 2182: Organization of HHA
- 2182.1: Characteristics Differentiating Branches From Subunits of HHAs
- 2182.2: Guidelines for Determining Parent, Branch, or Subunit
- 2182.3: Processing A change From Branch to Subunit
- 2182.4: CMS Approval Necessary for Non-Parent Locations
- 2182.4A: Notification by HHA to Add Non-Parent Location
- 2182.4B: SA Review of Requirement for Branch Determination

- 2182.4C: Onsite Monitoring of Approved Branches by the SA
- 2182.4D: Drop Sites
- 2182.5: Branch Identification Numbers
- 2183: Separate Entities (Separate Lines of Business)
- 2183.1: Operation of the HHA
- 2183.2: Consumer Awareness
- 2183.3: Staff Awareness
- 2184: Operation of HHAs Cross State Lines
- 2186: Health Facility-Based HHAs
- 2188: Survey of State-Operated HHAs
- 2194: Surveying Health Maintenance Organization (HMO)-Operated Home Health Agencies (HHAs) Providing Home Health Services Through Medicare Survey and Certification Process
- 2195: Guidelines for Determining Survey Frequency
- 2195.1: Tracking and Monitoring the Survey Cycles
- 2202: Outcome and Assessment Information Set (Oasis) Requirements
- 2202.1: OASIS Related Definitions
- 2202.2: History of OASIS
- 2202.2A: Current Version of OASIS
- 2202.2B: OASIS as Part of the HHA's Comprehensive Assessment
- 2202.2C: Incorporation of OASIS Data Items Into the Comprehensive Assessment
- 2202.3A: Medicare and Medicaid Patients
- 2202.3B: OASIS and the Medicare Home Health Benefit
- 2202.3C: Non-Medicare/Non-Medicaid Patients
- 2202.3D: Skilled Versus Nonskilled Care
- 2202.3E: Agencies Serving Medicaid Waiver and State Plan Patients
- 2202.3F: Patients Turning 18
- 2202.3G: Patients Receiving Maternity Services
- 2202.4: Comprehensive Assessment and OASIS Reporting
- 2202.4A: Comprehensive Assessment and OASIS Collection
- 2202.4B: OASIS Encoding and Locking
- 2202.4C: OASIS Reporting
- 2202.5: Outcome-Based Quality Improvement (OBQI)
- 2202.5A: Using Outcome Based Quality Monitoring (OBQM) and Risk Adjusted OBQI Reports in the Survey Process
- 2202.5B: Case-Mix Stratified Sample
- 2202.5C: Privacy Act Requirements
- 2202.5D: Accessing the OBQM, OBQI, and Process Based Quality Improvement (PBQI) Reports
- 2202.5E: Role of the OASIS Coordinators in OBQI
- 2202.6A: OASIS User's Manual
- 2202.6B: Other Manuals
- 2202.6C: Other Teaching Tools
- 2202.7: OASIS and the Home Health Prospective Payment System (PPS)
- 2202.8: Surveying for the OASIS Requirements
- 2202.8A: Condition of Participation: Comprehensive Assessment of Patients
- 2202.8B: Record Keeping
- 2202.8C: Condition of Participation: Reporting OASIS Information
- 2202.8D: Condition of Participation: Release of Patient Identifiable OASIS Information
- 2202.9: Patient Notification of OASIS Collection and Reporting
- 2202.9A: Informing Patients of OASIS Collection and Reporting
- 2202.9B: Right to See, Review, and Request Changes
- 2202.10: OASIS and HHAs Seeking Initial Certification

- 2202.10A: Determining Compliance With the OASIS Transmission Requirements
- 2202.10B: HHAs Seeking Initial Certification Through Deemed Status
- 2202.10C: Exceptions to Demonstrating Compliance With OASIS Submission Requirements Prior to Approval
- 2202.10D: Compliance Dates and PPS
- 2202.10E: Instructions for Handling Medicare Patients in HHAs Seeking Initial Certification
- 2202.10F: Instructions to New HHAs Concerning all Other Patients
- 2202.11: Correction Policy
- 2202.11A: Determining When to Inactivate an Assessment
- 2202.11B: Deleting Assessments
- 2202.11C: Types of Corrections an HHA Can Make in HAVEN
- 2202.11D: Documentation of Corrected Assessments
- 2202.11E: Clinical Implications of Corrected Assessment Records
- 2202.11F: Regarding Corrections in Lieu of Required Assessments
- 2202.11G: Timeliness of Corrections
- 2202.11H: Multiple Corrections in a Record
- 2202.12: OASIS State System
- 2202.12A: System Description
- 2202.12B: Administration Requirements
- 2202.12C: Validation and Editing Process
- 2202.12D: Reports
- 2202.12E: Replication to the CMS Repository
- 2202.12F: System Security
- 2202.12G: Security of Transmission
- 2202.12H: Provider Relations
- 2202.13: Protection of the Confidentiality of OASIS Data
- 2202.13A: OASIS System of Records
- 2202.13B: Protection of Confidentiality Under the Privacy Act of 1974
- 2202.14: SA and RO Roles and Responsibilities
- 2202.14A: State
- 2202.14B: Regional Office
- 2202.15C: HHAs
- 2202.16: Fax Transmission of OASIS or Other Patient Identifiable Information
- 2202.17: Change of Ownership, Merger, and Termination Procedures Affecting HHAs and OASIS Requirements
- 2202.18: Wound Ostomy Continence Nurses Society (WOCN) OASIS Guidance
- 2202.19: OASIS Collection on Private Pay (Non-Medicare/Non-Medicaid) Patients

IOM – "State Operations Manual," Pub. 100-07, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf
Chapter 3, "Additional Program Activities," includes several references to HHAs, such as termination and appeal as well as change in size. Sections that apply to HHAs include:

- 3034D: For HHAs and Hospices
- 3220B: Services Not In Compliance (HHAs, RHCs, and ESRD Facilities)
- 3222A: HHA's Request to Provide OPT Services on Its Premises
- 3330: HHA Toll-Free Hotline and Investigative Unit
- 3330A: HHA Hotline Function
- 3330B: HHA Hotline Information

IOM – "State Operations Manual," Pub. 100-07, Appendix B

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/downloads/som107ap_b_hha.pdf
Appendix B "Guidance to Surveyors: Home Health Agencies," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors.

Webpage – Survey & Certification – General Information – Accreditation of Medicare Certified Providers & Suppliers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html
This webpage provides information on Accreditation Organizations (AOs) and a list of organizations qualified to provide accreditation to providers enrolled in the Medicare Program.

Webpage – Survey & Certification – Certification & Compliance – Home Health Providers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs.html
This webpage provides basic information about being certified as a Medicare home health provider and includes links to the home health section of Chapter 2 of the "State Operations Manual," the Guidance for Laws & Regulations for HHAs, OASIS, HHA PPS, and relevant sections of the Code of Federal Regulations (CFR) and Social Security Act.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participation (CoPs) – Home Health Agencies

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/homehealth.html
This webpage explains that the existing CoPs are the minimum health and safety standards that an HHA must comply with to qualify for payment under the Medicare Program. Also included on this page is a listing of the relevant sections of the CFR and links to Home Health PPS, and Conditions of Participation for HHAs.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Home Health Agencies

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/HHAs.html
This webpage explains that the Interpretive Guidelines serve to interpret and clarify the CoPs for HHAs. The Interpretive Guidelines merely define or explain the relevant statute and regulations and do not impose any requirements that are not otherwise set forth in statute or regulation.

The HHA survey is conducted in accordance with the appropriate protocols and substantive requirements in the statute and regulations to determine whether a citation of non-compliance is appropriate. Deficiencies are based on a violation of the statute or regulations, which, in turn, is to be based on observations of the HHA's performance or practices.

This webpage links to Appendix B of the "State Operations Manual" and the Survey & Certification - Enforcement webpage.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes the following sections relevant to coverage:

- 10.1: Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services – A Brief Description
- 10.2: Home Health Services

- 10.3: Supplementary Medical Insurance (Part B) – A Brief Description
- 40.2: A/B MAC (A) and (HHH) Service to Home Health Agencies (HHAs)

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes the following sections relevant to coverage:
- 30.1: Content of the Physician's Certification
- 30.2: Method and Disposition of Certifications for Home Health Services
- 30.3: Recertifications for Home Health Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
Chapter 7, "Home Health Services," includes the following sections relevant to coverage:
- 20: Conditions To Be Met for Coverage of Home Health Services
- 20.1.1: Background
- 20.1.2: Determination of Coverage
- 20.2: Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services
- 20.3: Use of Utilization Screens and "Rules of Thumb"
- 30: Conditions Patient Must Meet to Qualify for Coverage of Home Health Services
- 30.1.1: Patient Confined to the Home
- 30.1.2: Patient's Place of Residence
- 30.2: Services Are Provided Under a Plan of Care Established and Approved by a Physician
- 30.2.1: Content of the Plan of Care
- 30.2.2: Specificity of Orders
- 30.2.3: Who Signs the Plan of Care
- 30.2.4: Timeliness of Signature
- 30.2.5: Use of Oral (Verbal) Orders
- 30.2.6: Frequency of Review of the Plan of Care
- 30.2.7: Facsimile Signatures
- 30.2.8: Alternative Signatures
- 30.2.9: Termination of the Plan of Care – Qualifying Services
- 30.2.10: Sequence of Qualifying Services and Other Medicare Covered Home Health Services
- 30.3: Under the Care of a Physician
- 30.4: Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample), Physical Therapy, Speech-Language Pathology Services, or Has Continued Need for Occupational Therapy
- 30.5: Physician Certification and Recertification of Patient Eligibility for Medicare Home Health Services
- 30.5.1: Physician Certification
- 30.5.1.1: Face-to-Face Encounter
- 30.5.1.2: Supporting Documentation Requirements
- 30.5.2: Physician Recertification
- 30.5.3: Who May Sign the Certification or Recertification
- 30.5.4: Physician Billing for Certification and Recertification
- 40: Covered Services Under a Qualifying Home Health Plan of Care
- 40.1: Skilled Nursing Care
- 40.1.1: General Principles Governing Reasonable and Necessary Skilled Nursing Care
- 40.1.2: Application of the Principles to Skilled Nursing Services
- 40.1.2.1: Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

- 40.1.2.2: Management and Evaluation of a Patient Care Plan
- 40.1.2.3: Teaching and Training Activities
- 40.1.2.4: Administration of Medications
- 40.1.2.5: Tube Feedings
- 40.1.2.6: Nasopharyngeal and Tracheostomy Aspiration
- 40.1.2.7: Catheters
- 40.1.2.8: Wound Care
- 40.1.2.9: Ostomy Care
- 40.1.2.10: Heat Treatments
- 40.1.2.11: Medical Gases
- 40.1.2.12: Rehabilitation Nursing
- 40.1.2.13: Venipuncture
- 40.1.2.14: Student Nurse Visits
- 40.1.2.15: Psychiatric Evaluation, Therapy, and Teaching
- 40.1.3: Intermittent Skilled Nursing Care
- 40.2: Skilled Therapy Services
- 40.2.1: General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
- 40.2.2: Application of the Principles to Physical Therapy Services
- 40.2.3: Application of the General Principles to Speech-Language Pathology Services
- 40.2.4: Application of the General Principles to Occupational Therapy
- 40.2.4.1: Assessment
- 40.2.4.2: Planning, Implementing, and Supervision of Therapeutic Programs
- 40.2.4.3: Illustration of Covered Services
- 50.1: Skilled Nursing, Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
- 50.2: Home Health Aide Services
- 50.3: Medical Social Services
- 50.4: Medical Supplies (Except for Drugs and Biologicals Other Than Covered Osteoporosis Drugs) and the Use of Durable Medical Equipment
- 50.4.1: Medical Supplies
- 50.4.1.1: The Law, Routine and Nonroutine Medical Supplies, and the Patient's Plan of Care
- 50.4.1.2: Routine Supplies (Nonreportable)
- 50.4.1.3: Nonroutine Supplies (Reportable)
- 50.4.2: Durable Medical Equipment
- 50.4.3: Covered Osteoporosis Drugs
- 50.5: Services of Interns and Residents
- 50.6: Outpatient Services
- 50.7: Part-Time or Intermittent Home Health Aide and Skilled Nursing Services
- 50.7.1: Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care
- 50.7.2: Application of this Policy Revision
- 60.1: Post-Institutional Home Health Services Furnished During A Home Health Benefit Period – Beneficiaries Enrolled in Part A and Part B
- 60.2: Beneficiaries Who Are Enrolled in Part A and Part B, but Do Not Meet Threshold for Post-Institutional Home Health Services
- 60.3: Beneficiaries Who Are Part A Only or Part B Only
- 60.4: Coinsurance, Copayments, and Deductibles
- 70.1: Number of Home Health Visits Under Supplementary Medical Insurance (Part B)
- 70.2: Counting Visits Under the Hospital and Medical Plans
- 80: Specific Exclusions From Coverage as Home Health Services
- 80.1: Drugs and Biologicals
- 80.2: Transportation
- 80.3: Services That Would Not Be Covered as Inpatient Services

- 80.4: Housekeeping Services
- 80.5: Services Covered Under the End Stage Renal Disease (ESRD) Program
- 80.6: Prosthetic Devices
- 80.7: Medical Social Services Furnished to Family Members
- 80.8: Respiratory Care Services
- 80.9: Dietary and Nutrition Personnel
- 90: Medical and Other Health Services Furnished by Home Health Agencies
- 100: Physician Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)
- 110: Use of Telehealth in Delivery of Home Health Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes the following sections relevant to coverage:
- 60.4: Services Incident to a Physician's Service to Homebound Patients Under General Physician Supervision
- 60.4.1: Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes a reference to home health. There might be other NCDs of interest in these manuals. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by the Medicare Administrative Contractors.

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 240.7: Postural Drainage Procedures and Pulmonary Exercises
- 290.1: Home Health Visits to a Blind Diabetic
- 290.2: Home Health Nurses' Visits to Patients Requiring Heparin Injections

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)" includes:
- 100.1.1: Written Order Prior to Delivery – HHAs
- 100.2: Certificates of Medical Necessity (CMN)
- 100.2.1: Completion of Certificate of Medical Necessity Forms
- 100.2.3.2: HHA Recertification for Home Oxygen Therapy

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
Section 15.4.1.6, Home Health Agencies (HHAs), in Chapter 15, "Medicare Enrollment," discusses HHA certification and plan of care.

Presentation – Medicare Home Health Face-to-Face Requirement

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/face-to-face-requirement-powerpoint.pdf
The Affordable Care Act requires that a certifying physician or an allowed non-physician practitioner must have a face-to-face encounter with every home health beneficiary as a condition for payment. This presentation provides information on the face-to-face requirement.

Presentation – Certifying Patients for the Medicare Home Health Benefit

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-16-HHBenefit-HL.pdf
The Affordable Care Act requires that a certifying physician or an allowed non-physician practitioner must have a face-to-face encounter with every home health beneficiary as a condition for payment. This presentation provides a benefit overview, patient eligibilty for home health services, coverage of services, certification requirements, including the face-to-face requirement, recertification requirements and physician billing for certification/recertification.

Educational Tool – "Home Health Face-to-Face Encounter Question & Answers"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/QandAsFull-revised-062712.pdf
This educational tool is intended for physicians who refer beneficiaries for the Medicare home health benefit, home health agencies, and NonPhysician practitioners (NPPs).

MLN Matters® Article – SE1219 "A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1219.pdf
This Special Edition MLN Matters® article is intended for physicians who refer beneficiaries to home health, order home health services, and/or certify eligibility for the Medicare home health benefit, home health agencies, and Non-Physician Practitioners (NPPs).

MLN Matters® Article – SE1436 "Certifying Patients for the Medicare Home Health Benefit"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf
This MLN Matters® Special Edition Article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Part A Home Health Services

MLN Matters® Article – SE1305 Revised "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
This Special Edition MLN Matters® article explains that under Phase 1, Medicare alerted the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. Under Phase 2, Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that provider is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

Webpage – "Face-to-Face Encounter Requirement for Certain Durable Medical Equipment"

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment.html
This webpage explains that due to continued concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the

Affordable Care Act (ACA) for certain items of DME, CMS will not start actively enforcing or expect full compliance with the DME face-to-face requirements until further notice.

Part B Home Health Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," explains therapy benefits covered by the Medicare Program. Sections relevant to HHAs include:

- 10: Supplementary Medical Insurance (SMI) Provisions
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 220.1: Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.1: Care of a Physician/Nonphysician Practitioner (NPP)
- 220.1.2: Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 220.1.4: Requirement That Services Be Furnished on an Outpatient Basis
- 220.2: Reasonable and Necessary Outpatient Rehabilitation Therapy Services
- 220.3: Documentation Requirements for Therapy Services
- 220.4: Functional Reporting
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology
- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes references to an HHA in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf

- 170.1: Institutional and Home Care Patient Education Programs

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 240.7: Postural Drainage Procedures and Pulmonary Exercises
- 290.1: Home Health Visits to a Blind Diabetic
- 290.2: Home Health Nurses' visits to Patients Requiring Heparin Injections

Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
This page provides helpful information on therapy payment caps, billing scenarios, and therapy updates.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

Electronic Mailing List – Therapy Caps

https://list.nih.gov/cgi-bin/wa.exe?A0=THERAPY-CAPS-L
The therapy caps electronic mailing list is administered by CMS, which emails subscribers information regarding policy, publications, coding, payment, and educational material.

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contact and resources.

MLN Matters® Article – MM9448 "Therapy Cap Values for Calendar Year (CY) 2016"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9448.pdf
This MLN Matters® Article describes the CMS policy for outpatient therapy caps for CY 2016.

BILLING

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

PART A

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," includes Section 10.2.2, "Durable Medical Equipment (DME) Furnished as a Home Health Benefit."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections relevant to billing:

- 10.2: FI Jurisdiction of Requests for Payment
- 10.3: Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider
- 20: Provider Assignment to FIs and MACs
- 40.4: Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement
- 50.1.2: Beneficiary Request for Payment on Provider Record -- ASCX12 837 Institutional Claim Format and form CMS-1450

- 60.3.2: Inpatient and Outpatient Demand Billing Instructions
- 60.4.2: Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim
- 90: Patient is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
- 110.1: Categories of Health Insurance Records to Be Retained
- 110.3: Retention Period
- 130.5.1: Submitting Adjustment Requests
- 180.1: Background and Policy

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," includes section 30.6.1.5, "Health Insurance Query for Home Health Agencies (HIQH)" which provides HHA billing information.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf
Chapter 10 is entitled "Home Health Agency Billing" and includes the following sections relevant to billing Part A:

- 10: General Guidelines for Processing Home Health Agency (HHA) Claims
- 10.1.1: Creation of HH PPS and Subsequent Refinements
- 10.1.3: Configuration of the HH PPS Environment
- 10.1.4: The HH PPS Episode – Unit of Payment
- 10.1.5: Number, Duration, and Claims Submission of HH PPS Episodes
- 10.1.5.1: More Than One Agency Furnished Home Health Services
- 10.1.5.2: Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes on HH PPS Episodes
- 10.1.6: Split Percentage Payment of Episodes
- 10.1.7: Basis of Medicare Prospective Payment Systems and Case-Mix
- 10.1.8: Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: HHRGs and HIPPS Codes
- 10.1.9: Composition of HIPPS Codes for HH PPS
- 10.1.10: Provider Billing Process Under HH PPS
- 10.1.10.1: Grouper Links Assessment and Payment
- 10.1.10.2: Health Insurance Beneficiary Eligibility Inquiry for Home Health Agencies
- 10.1.10.3: Submission of Request for Anticipated Payment (RAP)
- 10.1.10.4: Claim Submission and Processing
- 10.1.11: Payment, Claim Adjustments and Cancellations
- 10.1.12: Request for Anticipated Payment (RAP)
- 10.1.13: Transfer Situation – Payment Effects
- 10.1.14: Discharge and Readmission Situation Under HH PPS – Payment Effects
- 10.1.15: Adjustments of Episode Payment – Partial Episode Payment (PEP)
- 10.1.16: Payment When Death Occurs During an HH PPS Episode
- 10.1.17: Adjustments of Episode Payment – Low Utilization Payment Adjustments (LUPAs)
- 10.1.18: Adjustments of Episode Payment – Special Submission Case:"No-RAP" LUPAs
- 10.1.19: Adjustments of Episode Payment – Confirming OASIS Assessment Items
- 10.1.19.1: Adjustments of Episode Payment – Therapy Thresholds
- 10.1.19.2: Adjustments of Episode Payment – Early or Later Episodes
- 10.1.21: Adjustments of Episode Payment – Outlier Payments
- 10.1.22: Multiple Adjustments of Episode Payments
- 10.1.24: Glossary and Acronym List
- 20: Home Health Prospective Payment System (HH PPS) Consolidated Billing
- 20.1.1: Responsibilities of Home Health Agencies

- 20.1.2: Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
- 20.1.3: Responsibilities of Hospitals Discharging Medicare Beneficiaries to Home Health Care
- 20.2: Home Health Consolidated Billing Edits in Medicare Systems
- 20.2.1: Nonroutine Supply Editing
- 20.2.2: Therapy Editing
- 20.2.3: Other Editing Related to Home Health Consolidated Billing
- 20.2.4: Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date
- 20.2.5: No RAP Received and Therapy Services Rendered in the Home
- 30.1: Health Insurance Eligibility Query to Determine Episode Status
- 30.2: CWF Response to Inquiry
- 30.3: Timeliness and Limitations of CWF Responses
- 30.4: Provider/Supplier Inquiries to Medicare Contractors Based on Eligibility Responses
- 30.5: National Home Health Prospective Payment Episode History File
- 30.6: Opening and Length of HH PPS Episodes
- 30.7: Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAPs and HHA Claim Activity
- 30.8: Other Editing for HH PPS Episodes
- 30.9: Coordination of HH PPS Claims Episodes With Inpatient Claim Types
- 30.11: Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File
- 40: Completion of Form CMS-1450 for Home Health Agency Billing
- 40.1: Request for Anticipated Payment (RAP)
- 40.2: HH PPS Claims
- 40.3: HH PPS Claims When No RAP is Submitted – "No-RAP" LUPAs
- 40.4: Collection of Deductible and Coinsurance from Patient
- 40.5: Billing for Nonvisit Charges
- 50: Beneficiary-Driven Demand Billing Under HH PPS
- 60: No Payment Billing
- 70.1: General
- 70.2: Input/Output Record Layout
- 70.3: Decision Logic Used by the Pricer on RAPs
- 70.4: Decision Logic Used by the Pricer on Claims
- 70.5: Annual Updates to the HH Pricer
- 80: Special Billing Situations Involving OASIS Assessments
- 100: Temporary Suspension of Home Health Services
- 110: Billing and Payment Procedures Regarding Ownership and CMS Certification Numbers (CCNs)
- 110.1: Billing Procedures for an Agency Being Assigned Multiple CCNs or a Change in CCN
- 110.2: Payment Procedures for Terminated HHAs
- 120: Payments to Home Health Agencies That Do Not Submit Required Quality Data

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," includes:

- 110: General Billing Requirements – for DME, Prosthetics, Orthotic Devices, and Supplies
- 110.4: Frequency of Claims for Repetitive Services (All Providers and Suppliers)
- 140.2: Billing for HHA Medical Supplies
- 212: Home Health Consolidated Billing and Supplies Provided by DMEPOS Suppliers

IOM – "Completing and Processing the Form CMS-1450 Data Set," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," instructs providers in how to complete the Form CMS-1450 or its electronic equivalent. It includes Section 75, "General Instructions for Completion of Form CMS-1450 for Billing."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 36

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c36.pdf
Chapter 36, "Competitive Bidding," includes Section 20.5.3, "Home Health Agencies," which explains that HHAs must submit a bid and be awarded a contract for DMEPOS Competitive Bidding Program to furnish competitively bids items directly to Medicare beneficiaries who maintain a permanent residence in a Competitive Bidding Area (CBA).

More Resources: Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) pathway for more information about HHA-supplied DMEPOS items for Medicare beneficiaries.

Webpage – Home Health PPS – Coding and Billing Information

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html
This webpage includes pertinent coding and billing information for HHAs and provides links to the HHA Case Mix Grouper. The Excel sheets found in the ZIP files under the Downloads section of this webpage include, by year, a list of HCPCS codes subject to consolidated billing.

MLN Matters® Article – MM7182 "New Home Health Claims Reporting Requirements for G Codes Related to Therapy and Skilled Nursing Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7182.pdf
This MLN Matters® article announces the requirement to report additional, and more specific, data about therapy and nursing visits on home health claims.

MLN Matters® Article – MM8893 "Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8893.pdf
This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

MLN Matters® Article – MM8136 Revised "Data Reporting on Home Health Prospective Payment System (HH PPS) Claims"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8136.pdf
This MLN Matters® article describes new data reporting requirements for HH PPS claims. HHAs must report new codes indicating the location of where services were provided and indicating whether services were added to the HH plan of care by a physician who did not certify the plan of care.

More Resources: Refer to the Medicare Learning Network® booklet titled "Medicare Billing Information for Rural Providers and Suppliers" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html for more information regarding billing for rural services.

OASIS

Webpage – Outcome and Assessment Information Set (OASIS)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html
This webpage is used to store and disseminate policy and technical information related to OASIS data set for use by HHAs, State agencies, software vendors, professional associations and other Federal agencies in maintaining OASIS. This webpage also includes links to the several HHA webpages.

Webpage – Home Health Quality Initiative – OASIS User Manuals

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
This webpage explains OASIS-C is the current version of the OASIS data set and summarizes what is included in the "OASIS-C Guidance Manual." This manual and errata sheets are available in the Downloads section.

Webpage – Home Health PPS – OASIS – (Attachment D: Selection & Assignment of OASIS Diagnosis) Guidance

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/OASIS_Attachment_D_Guidance.html
This webpage includes guidance for the OASIS Implementation Manual: Chapter 8 – "Attachment D: Selection and Assignment of OASIS Diagnosis." A link to Attachment D is available in the Downloads section.

Webpage – Outcome and Assessment Information Set (OASIS) – Data Set

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSet.html
This webpage explains OASIS items were designed for the purpose of enabling the rigorous and systematic measurement of beneficiary home health care outcomes, with appropriate adjustment forbeneficiary risk factors affecting those outcomes.

Webpage – Outcome and Assessment Information Set (OASIS) – jHAVEN

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/HAVEN.html
A new java-based application, jHAVEN, has been developed to replace HAVEN. jHAVEN software application is provided free from CMS for HHAs to use for submission of their OASIS data.

MLN Matters® Article – SE1115 Revised "Recently Enrolled Home Health Agencies (HHAs): Submit OASIS and HHCAHPS Data Promptly to Ensure Full Medicare Payment"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1115.pdf
This Special Edition MLN Matters® article provides information for Medicare-certified HHAs about the OASIS and Home Health Care Consumer Assessment of Health Providers and Systems (CAHPS) data requirements.

Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf
Chapter 10 is entitled "Home Health Agency Billing" and includes the following sections relevant to billing Part B:

- 90: Medical and Other Health Services Not covered Under the Plan of Care (Type of Bill 034X)
- 90.1: Osteoporosis Injections as HHA Benefit
- 90.2: Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes references to HHA billing of preventive and screening services in the following sections:

- 10.2: Billing Requirements
- 10.2.2.1: FI/AB MAC Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration
- 10.2.3: Bills Submitted to Regional Home Health Intermediaries (RHHIs)
- 120.1: Coding and Payment of DSMT Services
- 150.2.1: Fiscal Intermediary (FI) Billing Requirements

CLAIMS PROCESSING AND PAYMENT

PART A

IOM – "Medicare Policy Benefit Manual," Pub. 100-02, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
Chapter 7, "Home Health Services," includes the following information about HH PPS payment:

- 10: Home Health Prospective Payment System (HH PPS)
- 10.1: National 60-Day Episode Rate
- 10.2: Adjustments to the 60-Day Episode Rates
- 10.3: Continuous 60-Day Episode Recertification
- 10.4: Counting 60-Day Episodes
- 10.5: Split Percentage Payment Approach to the 60-Day Episode
- 10.6: Physician Signature Requirements for the Split Percentage Payments
- 10.7: Low Utilization Payment Adjustment (LUPA)
- 10.8: Partial Episode Payment (PEP) Adjustment
- 10.9: Outlier Payments
- 10.10: Discharge Issues
- 10.11: Consolidated Billing
- 10.12: Change of Ownership Relationship to Episodes Under PPS

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections relevant to claims processing:

- 80.2.1.1: Payment Ceiling Standards
- 80.3.2.2: Consistency Edits for Institutional Claims
- 140.1: Threshold Edit for Outpatient and Inpatient Part B Claims

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 10

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf
Chapter 10, "Home Health Agency Billing," includes Sections 50 "Beneficiary-Driven Demand Billing Under HH PPS" and 70.5, "Annual Updates to the Home Health (HH) Pricer." Other sections of Chapter 10, which include HHA payment information, are listed under Billing in this pathway so the sections are not listed again here.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)" includes:

- 30: General Payment Rules

- 110.2: Application of DMEPOS Fee Schedule
- 190: Contractor Application of Fee Schedule and Determination of Payments and Patient Liability for DME Claims
- 212: Home Health Consolidated Billing and Supplies Provided by DMEPOS Suppliers

IOM – "Medicare Financial Management Manual," Pub. 100-06, Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c12.pdf
Chapter 12, Instructions for Medicare Credit Balance Report Activities includes Section 20.5, Provider-Based Home Health Agencies (HHAs), which provides information on submitting the CMS-838.

Webpage – Home Health PPS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
This webpage presents an overview of the HH PPS and provides links to many helpful HH-specific resources such as coding and billing information, pricer, grouper, homebound Frequently Asked Questions (FAQs), regulations and notices, and OASIS.

Webpage – Home Health PPS – Home Health PPS Software

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html
This webpage provides information about participating in the beta testing of the Home Health grouper for the CMS Home Health Prospective Payment System (HH PPS). The Home Health Prospective Payment System (HH PPS) Grouper v4115 is available for download in the Downloads section.

Webpage – PC Pricer – Home Health Prospective Payment System (HH PPS) PC Pricer

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/HH.html
The HH PPS Pricer makes all payment calculations applicable under HH PPS, including percentage payments on requests for anticipated payments (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, significant change in condition (SCIC) adjustments and outlier payments.

Webpage – Home Health PPS – Home Health Prospective Payment System Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html
This webpage shows Federal regulations and notices for fiscal years and calendar years for the HH PPS. Annual updates to the HH PPS can be found on this webpage. The annual updates are typically released as a proposed rule in August of each year with a final rule published in November.

Booklet – "Home Health Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243662.html
Learn about Home Health Prospective Payment System (HH PPS) background; consolidated billing requirements; criteria that must be met to qualify for home health services; therapy services; elements of and updates to the HH PPS; billing and payment for home health services; and Home Health Quality Reporting Program.

MLN Matters® Article – SE1214 Revised "Home Health Agencies (HHAs) Avoid Payment Reductions! Participate in HHCAHPS (Consumer Assessment of Health Care Providers and Systems) Now!"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1214.pdf
This Special Edition MLN Matters® article reminds all HHAs of the requirement to participate in the Home Health

Care CAHPS (HHCAHPS) survey for beneficiaries served in April 2012 and after to be eligible for the full market basket payment increase for CY 2014.

Cost Reports

Paper-Based Manuals – "Home Health Agency HCFA 1728-86," Pub. 15-2, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 17, "Home Health Agency Cost Report Form HCFA-1728-86," Explains that Form HCFA-1728-86 must be used by all HHAs which are not provider based to which payment is made by Medicare.

Paper-Based Manuals – "The Provider Reimbursement Manual-Part 2," Pub. 15-2, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 32 is entitled "Home Health Agency Cost Report Form CMS-1728-94."

Webpage – Cost Reports

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/HHA.html
All HHAs must complete Form CMS-1728-94, which provides data used by Medicare in determining program payment. This webpage links to cost report files.

Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes Section 10.3 "Application of Financial Limitations" about therapy caps.

Webpage – National Correct Coding Initiative (NCCI) Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter XI includes guidelines for coding therapy services. Other sections might also be relevant to HHAs billing Part B.

MLN Matters® Article – MM7050 Revised "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf
This MLN Matters® article provides information on the MPPR to the Practice Expense (PE) component of payment of select therapy services paid under the Medicare Physician Fee Schedule (MPFS). Many therapy services are time-based codes, meaning multiple units may be billed for a single procedure. CMS is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same beneficiary on the same day, for example, the MPPR applies to multiple units as well as multiple procedures.

MLN Matters® Article – MM8036 Revised "Manual Medical Review of Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8036.pdf
This MLN Matters® article discusses requirements for requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections relevant to beneficiary notices:

- 60.1.1: Basic Payment Liability Conditions
- 150.3: Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
- 150.3.1: Scope of Issuance of Expedited Determination Notices
- 150.3.2: General Responsibilities of QIOs and FIs Related to Expedited Determinations
- 150.3.3: Billing and Claims Processing Requirements Related to Expedited Determinations

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)," includes several references to home health in regards to Medicare Advantage Plans including Quality Improvement Organization (QIO) expedited review.

Webpage – Beneficiary Notices Initiative (BNI) – FFS ED Notices

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
This webpage provides information and links to the Fee-For-Service (FFS) Expedited Determination (ED) Notices used by HHAs, Forms CMS-10123 and CMS-10124, as well as completion instructions and ED questions and answers.

Webpage – Beneficiary Notices Initiative (BNI) – FFS ABN

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
This webpage provides information on the revised ABN (Form CMS-R-131) for all situations where Medicare payment is expected to be denied. Providers can also link to the form and instructions from this page.

QUALITY

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)" explains that QIOs review complaints raised by enrollees about the quality of care provided by HHAs.

Webpage – Home Health Quality Initiative

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html
This webpage provides an overview of home health quality initiatives and has a number of links regarding OASIS. There is also a link to CMS Educational Resources, and a Spotlight for new information. By selecting Educational Resources, links to online training videos and other educational resources are available.

Webpage – Home Health Compare

https://www.medicare.gov/homehealthcompare
From this webpage, the Home Health Compare Tool provides access to a number of outcome and process quality measures. This tool provides detailed information about every Medicare-certified HHA in the country.

Website – Home Health Care CAHPS Survey

https://www.homehealthcahps.org
The Consumer Assessment of Health Care Providers and Systems (CAHPS®) Home Health Care Survey (HHCAHPS) is designed to measure the experiences of people receiving home health care from Medicare-certified HHAs. The HHCAHPS is conducted for HHAs by approved Survey vendors. This website provides training and information about Survey protocols, samples and data submission.

OTHER RESOURCES

Other helpful, official resources are included in this section.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following sections regarding review of HHAs:

- 6.2: Medical Review of Home Health Services
- 6.2.1: Physician Certification of Patient Eligibility for the Medicare Home Health Benefit
- 6.2.1.1: Certification Requirements
- 6.2.2: Physician Certification
- 6.2.2.1: Recertification Elements
- 6.2.3: The Use of the Patient's Medical Record Documentation to Support the Home Health Certification
- 6.2.4: Coding
- 6.2.5: Medical Necessity of Services Provided
- 6.2.6: Examples of Sufficient Documentation Incorporated Into a Physician's Medical Record
- 6.2.7: Medical Review of Home Health Demand Bills

Webpage – Home Health PPS – Home Health Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Transmittals.html
This webpage shows the transmittals that are directed to the Home Health provider community, but the list may not include all instructions for which Home Health providers are responsible. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html
This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Home Health services are considered DHS.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This FAQs webpage allows providers to ask questions related to Medicare. Search under the terms HHA or home health for related questions and answers. For example, FAQ2389 addresses the CMS policy about the homebound status of home health beneficiaries who can drive.

Website – Office of Inspector General, U.S. Department of Health & Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about HHAs. Use the search feature on the home page of this website to review these.

Electronic Mailing List – HH PPS

https://list.nih.gov/cgi-bin/wa.exe?A0=HH-PPS-L
The HHA electronic mailing list is administered by CMS, which emails subscribers information regarding home health policy, publications, coding, payment, and educational material.

Webpage – Open Door Forums – Home Health, Hospice & Durable Medical Equipment Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME.html
The Home Health, Hospice & Durable Medical Equipment open door forum addresses the concerns of these health care areas. This webpage provides opportunities for live dialogue between CMS and HHAs.

Booklet – "Discharge Planning"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908184.html
This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

Beneficiary Booklet – "Medicare and Home Health Care"

https://www.medicare.gov/Pubs/pdf/10969.pdf
This is the official U.S. government booklet about Medicare home health care benefits for people with Original Medicare.

HOSPICE

INTRODUCTION

This curriculum is designed as a pathway to Hospice Medicare resources.

DEFINITION: HOSPICE

A hospice is a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals, meets the Conditions of Participation (CoPs) for hospices, and has a valid Medicare provider agreement.

Webpage – Hospice Center

https://www.cms.gov/Center/Provider-Type/Hospice-Center.html
This webpage provides information for hospice services such as the most current wage index, general provider information, coding requirements, and a spotlight on new information.

Webpage – Hospice

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html
This webpage provides an overview about hospice care and links to transmittals, hospice regulations and notices, relevant sections of the Social Security Law, the Hospice Center, and to Hospice: Questions and Answers.

ENROLLMENT

A hospice submits the Form CMS-855A or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) electronic equivalent to a Medicare Administrative Contractor.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c01.pdf
Chapter 1, "General Overview," includes the following sections related to hospice enrollment:

- 40.1: Assignments of A/B MAC (A) and (HHH)
- 40.2: A/B MAC (A) and (HHH) Service to Home Health Agencies (HHAs)

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections relevant to hospices:

- 10.1: Provider Agreements
- 10.4: Term of Agreements
- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement
- 60: Hospice Defined
- 60.1: Subdivision of Organizations as Hospices
- 60.2: Arrangements by Hospices

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes information related to enrollment for hospice providers:

- 01: Foreword
- 20.1: FI Service to HHAs and Hospices

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," includes references to hospices in sections 05, "Definition of Provider and Supplier," and 30.6, "Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data."

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.7, "Hospices."

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," includes, "Accredited/Deemed Hospices."

- 1000A: Medicare Provisions
- 1018C: Deemed Providers/Suppliers (Excluding CLIA Laboratories)
- 1022A: AO Reporting Requirements

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections relevant to hospices:

- 2003C: Deemed Status Providers/Suppliers, Excluding CLIA
- 2005D2: Form CMS-855R
- 2012: SA Identifying Eligible Providers and Suppliers
- 2080A: Citations
- 2080B: Description
- 2080C: Hospice Core Services
- 2080C.1: Waiver of Certain Staffing Requirements
- 2080C.2: Contracting for Highly Specialized Services
- 2080C.3: Hospice Nursing Shortage Provision
- 2080D: Hospice Required Services
- 2080D.1: Hospice Interdisciplinary Group (IDG)
- 2081: Revoking Election of Hospice Care
- 2082: Discharge from Hospice Care
- 2083: Hospice Regulations and Non-Medicare Patients
- 2084: Hospice Inpatient Services
- 2084A: Hospice Provides Inpatient Care Directly
- 2084B: Hospice Provides Inpatient Services Under Arrangements
- 2085: Operation of Hospice Across State Lines
- 2086: Hospice Change of Address
- 2086A: Effective Date
- 2086B: Administrative Review

- 2086C: Move After Certification Survey
- 2087: Simultaneous Surveys
- 2088: Multiple Locations
- 2089: Survey Requirements When the Hospice Provides Care to Residents of a SNF/NF or ICF/IID

IOM – "State Operations Manual," Pub. 100-07, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf
Chapter 3, "Additional Program Activities," includes Section 3034D, "For HHAs and Hospices," which discusses payment after termination of the provider.

IOM – "State Operations Manual," Pub. 100-07, Appendix M

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
Appendix M "Guidance to Surveyors: Hospice," provides information on Hospice conditions of participation that must be met in order to participate in the Medicare Program.

Webpage – Survey & Certification General Information – Accreditation of Medicare Certified Providers & Suppliers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html
This webpage provides information on Accreditation Organizations (AOs) and a list of organizations qualified to provide accreditation to hospices enrolled in the Medicare Program.

Webpage – Survey & Certification – Certification & Compliance – Hospices

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospices.html
This webpage provides basic information about being certified as a Medicare hospice provider and includes links to the hospice section of Chapter 2 of the "State Operations Manual" and relevant sections of the Code of Federal Regulations (CFR) and Social Security Act.

Webage – Conditions for Coverage (CfCs) & Conditions of Participation (CoPs) – Hospice

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospice.html
This webpage explains that CoPs are the health and safety requirements that all hospices will be required to meet, and that they are a flexible framework for continuous quality improvement in hospice care and reflect current standards of practice. Also included on this page is a listing of the relevant sections of the CFR and links to helpful hospice resources.

Webpage – Survey & Certification – Guidance To Laws & Regulations – Hospice

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Hospice.html
This webpage explains that Interpretive Guidelines serve to interpret and clarify the CoPs for hospices. The Interpretive Guidelines merely define or explain the relevant statute and regulations and do not impose any requirements that are not otherwise set forth in statute or regulation.

The hospice survey is conducted in accordance with the appropriate protocols and substantive requirements in the statute and regulations to determine whether a citation of non-compliance is appropriate. Deficiencies are based on a violation of the statute or regulations, which, in turn, is to be based on observations of the hospice's performance or practices.

This webpage links to Appendix M of the "State Operations Manual" and the Certification and Compliance for Hospice webpage.

Form – Instructions for Completing Hospice Request for Certification in The Medicare Program Form CMS-417

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms417.pdf
This form is required to obtain or retain Medicare eligibility. It serves two purposes. First, it provides basic information about the hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

COVERAGE

Podcast – "Hospice Related Services – Part B"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908995-podcast.html
This podcast is designed to provide education on the hospice benefit covered by the Medicare Program. It includes information on election, coverage, revoking the election of hospice and correct use of the modifier on claims.

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.1, "Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services – A Brief Description."

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes Section 60, "Certification and Recertification by Physicians for Hospice Care."

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections:

- 60: Hospice Defined
- 60.1: Subdivision of Organizations as Hospices
- 60.2: Arrangements by Hospices

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 8

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," includes the following sections related to hospice coverage for a beneficiary in a SNF:

- 10.2: Medicare SNF Coverage Guidelines Under PPS
- 20.3.1: Payment Bans on New Admissions

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," includes the following sections:

- 10: Requirements – General
- 20.1: Timing and Content of Certification
- 20.2: Election, Revocation and Discharge
- 20.2.1: Hospice Election

- 20.3: Election by Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries
- 20.4: Election by Managed Care Enrollees
- 40: Benefit Coverage
- 40.1: Covered Services
- 40.1.1: Nursing Care
- 40.1.2: Medical Social Services
- 40.1.3: Physicians' Services
- 40.1.3.1: Attending Physician Services
- 40.1.3.2: Nurse Practitioners as Attending Physicians
- 40.1.4: Counseling Services
- 40.1.5: Short-Term Inpatient Care
- 40.1.6: Medical Appliances and Supplies
- 40.1.7: Hospice Aide and Homemaker Services
- 40.1.8: Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 40.1.9: Other Items and Services
- 40.2.1: Continuous Home Care (CHC)
- 40.2.2: Respite Care
- 40.2.3: Bereavement Counseling
- 40.2.4: Special Modalities
- 40.3: Contracting With Physicians
- 40.4: Core Services
- 40.4.1: Contracting for Core Services
- 40.4.1.1: Contracting for Highly Specialized Nursing Services
- 40.4.2: Waiver for Certain Core Staffing Requirements
- 40.4.2.1: Waiver for Certain Core Nursing Services
- 40.5: Non-core Services
- 50: Limitation on Liability for Certain Hospice Coverage Denials
- 60: Provision of Hospice Services to Medicare/Veteran's Eligible Beneficiaries
- 70: Hospice Contracts with An Entity for Services not Considered Hospice Services
- 70.1: Instructions for the Contractual Arrangement
- 80: Hospice Pre-Election Evaluation and Counseling Services
- 80.1: Documentation

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
Chapter 11, "End Stage Renal Disease (ESRD)," includes section 40, "Other Services" related to hospice coverage.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions From Coverage," includes Section 110.1, "Custodial Care Under a Hospice Program," which explains care furnished to an individual who has elected the hospice care option is custodial only if it is not reasonable and necessary for the palliation or management of the terminal illness or related conditions.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to hospice in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database on the Centers for Medicare & Medicaid Services (CMS) website, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 280.14: Infusion Pumps

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," references hospices in Section 05, "Definition of Provider and Supplier," and Section 30.6, "Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data."

Presentation – "Face-to-Face Requirement Affecting Hospice Recertification"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/downloads/HospiceFace-to-FaceGuidance.pdf
The Affordable Care Act requires that a hospice physician or Nurse Practitioner (NP) must have a face-to-face encounter with every hospice beneficiary to determine the continued eligibility of that beneficiary prior to the 180th day recertification, and prior to each subsequent recertification. This presentation provides information on the face-to-face requirement.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," refers to hospices in the following sections:
- 01: Foreword
- 10.2: FI Jurisdiction of Requests for Payment
- 10.3: Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider
- 20: Provider Assignment to FIs and MACs
- 20.1: FI Service to HHAs and Hospices
- 30.2.10: Payment Under Reciprocal Billing Arrangements – Claims Submitted to Carriers
- 40.4: Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement
- 50.2.2: Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services
- 50.2.3: Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment
- 50.2.4: Reprocess Inpatient or Hospice Claims in Sequence
- 60.1: General Information on Non-covered Charges on Institutional Claims
- 60.1.1: Basic Payment Liability Conditions
- 60.4: Noncovered Charges on Outpatient Bills
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services
- 80.3.2.2: Consistency Edits for Institutional Claims
- 80.3.3: Timeliness Standards for Processing Other-Than-Clean Claims
- 130.1.3: Late Charges
- 140.1: Threshold Edit for Outpatient and Inpatient Part B Claims

- 150.3: Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
- 150.3.1: Scope of Issuance of Expedited Determination Notices
- 190: Payer Only Codes Utilized by Medicare

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," references hospices in Section 05, "Definition of Provider and Supplier," and Section 30.6, "Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf
Chapter 11, "Processing Hospice Claims," includes the following sections regarding billing of hospice services:

- 10: Overview
- 10.1: Hospice Pre-Election Evaluation and Counseling Services
- 20.1: Procedures for Hospice Election
- 20.1.1: Notice of Election (NOE) – Form CMS-1450
- 20.1.2: Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election
- 20.1.3: A/B MAC (HHH) Reply to Notice of Election
- 30.1: Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH)
- 30.2: Payment Rates
- 30.2.1: Payments to Hospice Agencies That Do Not Submit Required Quality Data
- 30.3: Data Required on the Institutional Claim to A/B MAC (HHH)
- 30.4: Claims From Medicare Advantage Organizations
- 40.1: Types of Physician Services
- 40.1.1: Administrative Activities
- 40.1.2: Hospice Attending Physician Services
- 40.1.3: Independent Attending Physician Services
- 40.1.3.1: Care Plan Oversight
- 40.2: Processing Professional Claims for Hospice Beneficiaries
- 40.2.1: Claims After the End of Hospice Election Period
- 50: Billing and Payment for Services Unrelated to Terminal Illness
- 60: Billing and Payment for Services Provided by Hospices Under Contractual Arrangements With Other Institutions
- 60.1: Instructions for the Contractual Arrangement
- 60.2: Clarification of the Payment for Contracted Services
- 70.1: General
- 70.2: Coinsurance on Outpatient Drugs and Biologicals
- 70.3: Coinsurance on Inpatient Respite Care
- 90: Frequency of Billing and Same Day Billing
- 100: Billing for Hospice Denials
- 100.1: Billing for Denial of Room and Board Charges
- 100.2: Demand Billing for Hospice General Inpatient Care

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set" includes section 75.2, "Form Locators 16-30" which clarifies hospices must include patient discharge status on their claims.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes the following sections for hospice billing:

- 20: Billing Requirements for Coverage of Kidney Disease Patient Education Services
- 20.1: Additional Billing Requirements Applicable to Claims Submitted to Fiscal Intermediaries (FIs)

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 40, "Role of A/B MACs (A) and (HHH)."

IOM – "Medicare General Information, Eligibility and Entitlement Manual," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," includes Section 10.3, "Basis for Determining the Part A Coinsurance Amounts."

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," includes the following sections related to Hospice claims processing and payment:

- 30: Coinsurance
- 30.1: Drugs and Biologicals Coinsurance
- 30.2: Respite Care Coinsurance
- 80.2: Payment
- 90: Caps and Limitations on Hospice Payments
- 90.1: Limitation on Payments for Inpatient Care
- 90.2: Aggregate Cap on Overall Reimbursement to Medicare-certified Hospices
- 90.2.1: Actual Medicare Payments Counted
- 90.2.2: New Hospices
- 90.2.3: Counting Beneficiaries for Calculation
- 90.2.4: Changing Aggregate Cap Calculation Methods
- 90.2.5: Other Issues
- 90.2.6: Updates to the Cap Amount

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes information related to claims processing and payment for hospice providers:

- 10.2: FI Jurisdiction of Requests for Payment
- 10.3: Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider
- 50.2.4: Reprocess Inpatient or Hospice Claims in Sequence

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf
Chapter 11, "Processing Hospice Claims," includes the following sections regarding claims processing and payment of hospice services:

- 110: Medicare Summary Notice (MSN) Messages/ASC X12N Remittance Advice Adjustment Reason and Remark Codes
- 120: Contractor Responsibilities for Publishing Hospice Information

IOM – "Medicare Claims Processing Manual," 100-04 Chapter 23

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23, "Fee Schedule Administration and Coding Requirements," includes the following sections related to hospice payment:

- 30: Services Paid Under the Medicare Physician's Fee Schedule
- 30.3.2: A/B MAC (A), (B), or (HHH) Furnishing Physician Fee Schedule Data for National Codes
- 30.3.3: Furnishing other Fee Schedule, Prevailing Charge, and Conversation Factor Data
- 30.3.4: Responsibility to Obtain and Implement Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedules
- 30.3.5: File Specifications
- 40: Clinical Diagnostic Laboratory Fee Schedule

IOM – "Medicare Financial Management Manual," 100-06 Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c09.pdf
Chapter 9, "Provider Statistical & Reimbursement Report," includes Section 30.2, "Provider Summary Report," which summarizes claim data and other information by revenue code required for cost report settlement and CMS reporting purposes.

Paper Manual – 15-2 "Provider Reimbursement Manual – Part 2," Chapter 38

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 38 is "Hospice Cost Report (Form CMS-1984-99, Instructions)."

Fact Sheet – "Hospice Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243663.html
Learn about Medicare hospice benefit background and coverage, how payment rates are set and payment updates, and the Hospice Quality Reporting Program.

MLN Matters® Article – MM8876 "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program and the Hospice Pricer for Fiscal Year (FY) 2015"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8876.pdf
This MLN Matters® article provides information on the annual update to hospice payment rates, hospice wage index and Pricer for Fiscal Year (FY) 2015, and the annual update of the hospice cap amount for the 2015 cap year.

MLN Matters® Article – MM8142 "Hospice Monthly Billing Requirement"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8142.pdf
This MLN Matters® article explains system edits to return hospice claims to the provider when the hospice has submitted more than one claim per month per beneficiary or when the hospice has submitted claims spanning more than 1 calendar month.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes information related to beneficiary notices for hospice beneficiaries:

- 60.1.1: Basic Payment Liability Conditions
- 150.3: Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
- 150.3.1: Scope of Issuance of Expedited Determination Notices
- 150.3.2: General Responsibilities of QIOs and FIs Related to Expedited Determinations
- 150.3.3: Billing and Claims Processing Requirements Related to Expedited Determinations

Webpage – Beneficiary Notices Initiative (BNI) FFS ED Notices

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
Hospice providers must use approved versions of the Expedited Determination (ED) notices. Links to the approved notices are provided on the this webpage.

QUALITY

Webpage – Hospice Quality Reporting

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
The Hospice Quality Reporting webpage provides links to information on hospice quality reporting including data submission of information. The Spotlight & Announcements and Data Submission links provide valuable information on The Hospice Quality Reporting Program Data Entry and Submission WebEx.

MLN Matters® Article – SE1301 "Hospice Quality Data Reporting Reminders"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1301.pdf
This Special Edition MLN Matters® article provides information to hospice providers on reporting hospice quality data.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health & Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about hospice. Use the search feature on the home page of this website to review these.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, as well as training and resources for hospice facilities.

Webpage – Open Door Forums: Home Health, Hospice & Durable Medical Equipment Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME.html
The Home Health, Hospice & Durable Medical Equipment Open Door Forum addresses the concerns of these health care areas.

Webpage – Hospice Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Transmittals.html
This webpage shows the transmittals that are directed to the hospice provider community, but the list may not include all instructions for which hospice providers are responsible. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Webpage – Hospice Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.html
This list includes proposed and final regulations and notices about Medicare hospice payment.

Webpage – Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term hospice for related questions and answers. For example, FAQ2357 addresses on-call phone consultations.

Electronic Mailing List – Hospice

https://list.nih.gov/cgi-bin/wa.exe?A0=HOSPICE-L
The hospice electronic mailing list is administered by CMS, which emails subscribers information regarding hospice policy, publications, coding, payment, and educational material.

Booklet – "Discharge Planning"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908184.html
This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

Beneficiary Publication – "Medicare Hospice Benefits"

https://www.medicare.gov/Pubs/pdf/02154.pdf
This booklet has information about Medicare's hospice care coverage.

Form – Instructions for Completing Hospice Request For Certification in The Medicare Program Form CMS-417

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms417.pdf
This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

OUTPATIENT PHYSICAL THERAPY, OTHER REHABILITATION, AND OUTPATIENT SPEECH PATHOLOGY FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Outpatient Physical Therapy, Other Rehabilitation, and Outpatient Speech Pathology Facility Medicare resources.

Definition: Outpatient Physical Therapy (OPT)/Other Rehabilitation Facility (ORF)/Outpatient Speech Pathology (OSP)

There are three types of organizations that may qualify as OPT/ORF/OSP providers. However, almost all OPT/ORF/OSP providers are rehabilitation agencies. These organizations are:

Definition: Rehabilitation Agency

An agency that provides an integrated, multidisciplinary program designed to upgrade the physical functions of handicapped, disabled individuals by bringing together, as a team, specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech-language pathology services and a rehabilitation program that, in addition to physical therapy or speech-language pathology services, includes social or vocational adjustment services. Occupational therapy cannot be substituted for the physical therapy requirement. It may be provided in addition to physical therapy or speech-language pathology services.

Definition: Clinic

A clinic is a facility established primarily for the provision of outpatient physicians' services. To meet the definition of a clinic, the facility must meet the following test of physician participation:

- The medical services of the clinic are provided by a group of three or more physicians practicing medicine together
- A physician is present in the clinic at all times during hours of operation to perform medical services (rather than only administrative services)

Definition: Public Health Agency

An official agency established by a State or local government, the primary function of which is to maintain the health of the population served by providing environmental health services, preventive medical services, and in certain instances, therapeutic services.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections:

- 10: Provider and Related Definitions
- 10.1: Provider Agreements

- 10.3: Under Arrangements
- 10.4: Term of Agreements
- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement

IOM – "Medicare Progarm Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.11, "Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)," which provides information on OPT/ORF/OSP enrollment in the Medicare Program.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections which provide information regarding the survey and certification of OPTs/ORFs/OSPs:

- 2290: Providers of Outpatient Physical Therapy and Speech-Language Pathology Services – Citations
- 2292: Types of Organizations, Who May Provide Outpatient Physical Therapy and Speech-Language Pathology Services, Specified in §485.701 - §485.729
- 2292A: Rehabilitation Agency
- 2292B: Rehabilitation Agency, Clinic and Public Health Agencies
- 2292C: Public Health Agency
- 2294: Change of Address
- 2296: Medicare Approved Sites of Service Provision
- 2298: Extension Locations for Rehabilitation Agencies
- 2298A: Criteria for Extension Location Approval
- 2298B: Extension Location Approval Process
- 2298C: Survey of Rehabilitation Agency Extension Locations by SAs
- 2298D: Accreditation Organization (AO) Surveys of Rehabilitation Agencies
- 2300: Outpatient Physical Therapy and/or Speech-Language Pathology Services at Other Locations such as a Patient's Private Residence, Assisted Living or Independent Living Facility
- 2302: CMS -381 Model Letter Requesting Identification of Extension Locations
- 2304: Operation of an Organization on the Premises of a Supplier/Provider
- 2306: When a Rehabilitation Agency's Extension Location Becomes Its Primary Site
- 2308: Relocations of Providers of Outpatient Physical Therapy and Outpatient Speech-Language Pathology Services Concurrent with CHOWs
- 2779L: Outpatient Physical Therapy (OPT) Extension CMS Certification Numbers

IOM – "State Operations Manual," Pub. 100-07, Appendix E

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_e_opt.pdf
Appendix E, "Guidance to Surveyors: Outpatient Physical Therapy or Speech Pathology Services," includes State survey information for OPTs/ORFs/OSPs.

Webpage – Survey & Certification – Certification & Compliance – Outpatient Rehabilitation Providers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/OutpatientRehab.html
This webpage provides basic information about being certified as a Medicare OPT/ORF/OSP provider and includes links to Chapter 2 of the "State Operations Manual," Survey and Certification General Enforcement Information, and relevant sections of the Code of Federal Regulations (CFR) and Social Security Act.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Clinics, Rehab Agencies, & Public Health Agencies as Providers of Outpatient PT and Speech Language

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/ProvidersofOutpatientServices.html
This webpage provides links to important resources regarding CfCs and CoPs for OPTs/ORFs/OSPs.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Outpatient Rehabilitation

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/OutpatientRehab.html
This webpage explains that survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations, and all surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of survey findings. This webpage provides a link to Appendix E of the "State Operations Manual" and to the Survey & Certification – Enforcement webpage.

Form – Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services Form CMS-1856

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1856.pdf
Submission of this form will initiate the process of obtaining a decision as to whether the conditions of participation are met.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," explains therapy benefits covered by the Medicare Program. Sections relevant to OPTs/ORFs/OSPs include:

- 100: Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 220.1: Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.1: Care of a Physician/Nonphysician Practitioner (NPP)
- 220.1.2: Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 220.1.4: Requirement That Services Be Furnished on an Outpatient Basis
- 220.2: Reasonable and Necessary Outpatient Rehabilitation Therapy Services
- 220.3: Documentation Requirements for Therapy Services
- 220.4: Functional Reporting
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology
- 230.5: Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP)
- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes policies related to occupational or physical therapists and speech-language pathologists in specific NCDs. There might be other NCDs of interest in these manuals. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Administrative Contractors.

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf
- 160.12: Neuromuscular Electrical Stimulator (NMES)
- 160.27: Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf
- 170.1: Institutional and Home Care Patient Education Programs
- 170.3: Speech-Language Pathology Services for the Treatment of Dysphagia

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- 240.7: Postural Drainage Procedures and Pulmonary Exercises

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

Form – Plan of Treatment for Outpatient Rehabilitation Form CMS-700

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS700.pdf
This form may be used to establish an outpatient rehabilitation plan of treatment.

Form – Updated Plan of Progress for Outpatient Rehabilitation Form CMS-701

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS701.pdf
This form may be used to update the outpatient rehabilitation plan of treatment.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about OPT/ORF billing:
- 20.1: Discipline Specific Outpatient Rehabilitation Modifiers – All Claims
- 20.2: Reporting of Service Units With HCPCS

- 20.3: Determining What Time Counts Towards 15-Minute Timed Codes – All Claims
- 20.4: Coding Guidance for Certain CPT Codes - All Claims
- 20.5: CORF/OPT Edit for Billing Inappropriate Supplies
- 40.2: Applicable Types of Bill
- 40.3: Applicable Revenue Codes
- 40.4: Edit Requirements for Revenue Codes
- 40.5: Line Item Date of Service Reporting
- 40.6: Non-covered Charge Reporting
- 50: CWF and PS&R Requirements – A/B MAC (A)
- Addednum A - Chapter 5, Section 20.4 - Coding Guidance for Certain CPT Codes - All Claims

Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
This page provides helpful information on therapy payment caps, billing scenarios, and therapy updates.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

MLN Matters® Article – MM9448 "Therapy Cap Values for Calendar Year (CY) 2016"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9448.pdf
This MLN Matters® article describes the CMS policy for outpatient therapy caps for CY 2016.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about OPT/ORF/OSP claims processing and payment:

- 10: Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General
- 10.1: New Payment Requirement for A/B MACs (A)
- 10.2: The Financial Limitation Legislation
- 10.3: Application of Financial Limitations
- 10.4: Claims Processing Requirements for Financial Limitations
- 10.5: Notifications for Beneficiaries Exceeding Financial Limitations
- 10.6: Functional Reporting
- 10.7: Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services
- 40.1: Determining Payment Amounts - Institutional Claims
- 50: CWF and PS&R Requirements – A/B MAC (A)

Paper-Based Manual – "The Provider Reimbursement Manual – Part 1," Pub. 15-1, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 14, "Reasonable Cost of Therapy and Other Services," includes information relevant to outpatient therapy services.

Webpage – National Correct Coding Initiative (NCCI) Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage offers a link to the "NCCI Policy Manual for Medicare Services" under the Downloads section. Chapter 11, "Medicine, Evaluation and Management Services (CPT Codes 90000-99999)," includes coding information relevant to services performed by an occupational or physical therapist. In addition, OPTs/ORFs/OSPs should click on the NCCI Coding Edits to search for applicable NCCI edits.

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MLN Matters® Article – MM7050 Revised "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf
This MLN Matters® article provides information on the MPPR to the Practice Expense (PE) component of payment of select therapy services paid under the Medicare Physician Fee Schedule (MPFS). Many therapy services are time-based codes, meaning multiple units may be billed for a single procedure. CMS is applying an MPPR to the practice expense payment when more than one unit or procedure is provided to the same beneficiary on the same day, the MPPR applies to multiple units as well as multiple procedures.

MLN Matters® Article – MM8036 Revised "Manual Medical Review of Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8036.pdf
This MLN Matters® article discusses requirements for requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes Section 10.5, "Notification for Beneficiaries Exceeding Financial Limitations," which provides information regarding the issuance of ABNs in the OPT/ORF/OSP setting.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about outpatient therapy services. Use the search feature on the home page of this website to review these.

Webpage – Physician Self Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html

This webpage explains that the Stark Law prohibits a physician from referring a Medicare beneficiary for certain Designated Health Services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Occupational therapy services, physical therapy services, and outpatient speech-language pathology services are considered DHS.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term therapy for related questions and answers. For example, FAQ2001 answers a question about therapy caps.

Electronic Mailing List – Therapy-Caps

https://list.nih.gov/cgi-bin/wa.exe?A0=THERAPY-CAPS-L
The therapy caps electronic mailing list is administered by CMS, which emails subscribers information regarding therapy caps.

Podcast – "Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2012-05-21OutpatientTherapyServices.html
This podcast is designed to provide education on the documentation and coverage requirements needed to submit Medicare claims for outpatient rehabilitation therapy services. It includes information from the Medicare Learning Network® fact sheet titled "Outpatient Rehabilitation Therapy Services – Complying with Documentation Requirements," which describes common Comprehensive Error Rate Testing Program errors related to Outpatient Rehabilitation Therapy Services.

SKILLED NURSING FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Skilled Nursing Facility Medicare resources.

DEFINITION: SKILLED NURSING FACILITY (SNF)

A SNF is a facility which:

- Is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care; or
- Is primarily engaged in providing to residents skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- On a regular basis engaged in providing health-related care and services to beneficiaries who because of their mental or physical condition require care and services which is available to them only through these facilities and is not primarily for the care and treatment of mental diseases;
- Has in effect a transfer agreement (meeting the requirements of the Social Security Act with one or more hospitals having agreements in effect under the Social Security Act); and
- Meets the requirements for a SNF described in the Social Security Act.

Webpage – Skilled Nursing Facility Center

https://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html
The Skilled Nursing Facility Center contains helpful links to billing/payment, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations, contacts, and educational resources for SNF providers.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections about SNFs:

- 10.1: Provider Agreements
- 10.4.1: Agreement with a SNF
- 10.6.1: Voluntary Termination
- 10.6.2: Involuntary Termination, Including SNF Agreement Cancellations
- 10.6.3: Expiration and Renewal – Nonrenewal of SNF Term Agreements
- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement
- 30: Skilled Nursing Facility Defined
- 30.1: Distinct Part of an Institution as a SNF
- 30.2: Transfer Agreements
- 30.3: Hospital Providers of Extended Care Services

IOM – "State Operations Manual," Pub. 100-07, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c07.pdf
Chapter 7, "Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities," includes Section 7008, "Types of Facilities That May Qualify as Skilled Nursing Facilities and Nursing Facilities."

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.14, "Skilled Nursing Facilities (SNFs)."

Fact Sheet – "Swing Bed Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html
Learn about swing bed services background, requirements that apply to hospitals and Critical Access Hospitals, and payments.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf
Chapter 3, "Additional Program Activities," includes several references to SNFs, such as termination and appeal as well as change in size. Sections that apply to SNFs include:

- 3034C: For Hospitals, CAHs, and SNFs
- 3202: Change in Size or Location of Participating SNF and/or NF
- 3202A: Requirements for Distinct Part Certification
- 3202A1: Meet Distinct Part Certification
- 3202A2: Do Not Meet Distinct Part Certification
- 3202B: Changes in Bed Size of Participating SNF and/or NF
- 3202C: General Request Filing Requirements
- 3202D: Exceptions
- 3202E: Change in Designated Bed Location(s)
- 3202F: RO or SA (as appropriate) Actions Upon Receipt of Written Request for Change in Bed Size/Location
- 3202G: Evaluation
- 3202H: Survey Considerations

IOM – "State Operations Manual," Pub. 100-07, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf
Chapter 5, "Complaint Procedures," provides information on investigation procedures if a complaint is made regarding a facility. SNF providers can learn about these procedures by reviewing this chapter.

IOM – "State Operations Manual," Pub. 100-07, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c07.pdf
Chapter 7, "Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities," provides information for conducting the nursing home survey, certification, and enforcement regulations.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Long Term Care Facilities

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/LTC.html
This webpage provides downloads of the "State Operations Manual" and "Restraint Reduction Assessment and Alternatives Help Guide for Skilled Nursing Facilities," as well as links to several helpful resources "Nursing Home Compare" and requirements for long term care facilities.

Webpage – Survey & Certification – Certification & Compliance – Nursing Homes

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html
This webpage provides basic information about being certified as a Medicare SNF and includes links to applicable laws, regulations, and compliance information. In the Downloads section there are related reports and compendia.

Webpage – Survey & Certification – Guidance to Laws & Regulations

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/index.html
This webpage explains survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements.

COVERAGE

PART A

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes the following sections about extended care services:

- 40: Certification and Recertification by Physicians for Extended Care Services
- 40.1: Who May Sign the Certification or Recertification for Extended Care Services
- 40.2: Certification for Extended Care Services
- 40.3: Recertifications for Extended Care Services
- 40.4: Timing of Recertifications for Extended Care Services
- 40.5: Delayed Certifications and Recertifications for Extended Care Services
- 40.6: Disposition of Certification and Recertifications for Extended Care Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c03.pdf
Chapter 3 "Duration of Covered Inpatient Services," includes the following sections about inpatient coverage:

- 10: Benefit Period (Spell of Illness)
- 20: Inpatient Benefit Days
- 20.1: Counting Inpatient Days
- 20.1.1: Late Discharge
- 20.1.2: Leave of Absence
- 20.1.3: Discharge or Death on First Day of Entitlement or Participation
- 30: Inpatient Days Counting Toward Benefit Maximums

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 8

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," includes the following sections related to SNF Part A coverage:

- 10: Requirements – General
- 10.1: Medicare SNF PPS Overview
- 10.2: Medicare SNF Coverage Guidelines Under PPS

- 10.3: Hospital Providers of Extended Care Services
- 20: Prior Hospitalization and Transfer Requirements
- 20.1: Three-Day Prior Hospitalization
- 20.1.1: Three-Day Prior Hospitalization – Foreign Hospital
- 20.2.1: General
- 20.2.2: Medical Appropriateness Exception
- 20.2.2.1: Medical Needs Are Predictable
- 20.2.2.2: Medical Needs Are Not Predictable
- 20.2.2.3: SNF Stay Prior to Beginning of Deferred Covered Treatment
- 20.2.2.4: Effect of Delay in Initiation of Deferred Care
- 20.2.2.5: Effect on Spell of Illness
- 20.2.3: Readmission to a SNF
- 20.3.1: Payment Bans on New Admissions
- 20.3.1.1: Beneficiary Notification
- 20.3.1.2: Readmissions and Transfers
- 20.3.1.3: Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period
- 20.3.1.4: Payment Under Part B During a Payment Ban on New Admissions
- 20.3.1.5: Impact of Consolidated Billing Requirements
- 20.3.1.6: Impact on Spell of Illness
- 30: Skilled Nursing Facility Level of Care – General
- 30.1: Administrative Level of Care Presumption
- 30.2.1: Skilled Services Defined
- 30.2.2: Principles for Determining Whether a Service is Skilled
- 30.2.3.1: Management and Evaluation of a Patient Care Plan
- 30.2.3.2: Observation and Assessment of Patient's Condition
- 30.2.3.3: Teaching and Training Activities
- 30.2.4: Questionable Situations
- 30.3: Direct Skilled Nursing Services to Patients
- 30.4.1.1: General
- 30.4.1.2: Application of Guidelines
- 30.4.2: Speech-Language Pathology
- 30.5: Nonskilled Supportive or Personal Care Services
- 30.6: Daily Skilled Services Defined
- 30.7: Services Provided on an Inpatient Basis as a "Practical Matter"
- 30.7.1: The Availability of Alternative Facilities or Services
- 30.7.2: Whether Available Alternatives Are More Economical in the Individual Case
- 30.7.3: Whether the Patient's Physical Condition Would Permit Utilization of an Available, More Economical Care Alternative
- 40: Physician Certification and Recertification for Extended Care Services
- 40.1: Who May Sign the Certification or Recertification for Extended Care Services
- 50: Covered Extended Care Services
- 50.1: Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse
- 50.2: Bed and Board in Semi-Private Accommodations Furnished in Connection With Nursing Care
- 50.3: Physical, Therapy, Speech-Language Pathology and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision
- 50.4: Medical Social Services to Meet the Patient's Medically Related Social Needs
- 50.5: Drugs and Biologicals
- 50.6: Supplies, Appliances, and Equipment
- 50.7: Medical Service of an Intern or Resident-in-Training
- 50.8.1: General
- 50.8.2: Respiratory Therapy
- 60: Covered Extended Care Days

- 70: Medical and Other Health Services Furnished to SNF Patients
- 70.1: Diagnostic Services and Radiological Therapy
- 70.2: Ambulance Service
- 70.3: Inpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services
- 70.4: Services Furnished Under Arrangements With Providers

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 9

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," includes the following sections related to SNFs:

- 20.3: Election by Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries
- 40.1.5: Short-Term Inpatient Care
- 70: Hospice Contracts with an Entity for Services not Considered Hospice Services

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
The following chapters of the "Medicare National Coverage Determinations (NCD) Manual" include a reference to Skilled Nursing Facility or SNF in a specific NCD. There might be other NCDs of interest to you in these manuals. You can also locate NCDs by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also identify Local Coverage Determinations (LCDs) by Medicare Administrative Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 70.2: Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility
- 70.5: Hospital and Skilled Nursing Facility Admission Diagnostic Procedures

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf

- 160.17: L-Dopa

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part3.pdf

- 170.1: Institutional and Home Care Patient Education Programs

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 240.7: Postural Drainage Procedures and Pulmonary Exercises

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," includes the following sections relevant SNF to coverage:

- 10.5: Hospital and Skilled Nursing Facility (SNF) Verification of Prior Hospital Stay Information for Determining Deductible and Benefit Period Status
- 10.12: SNF Verification of Prior Hospital Stay and Transfer Requirements

MLN Matters® Article – SE1308 Revised "Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1308.pdf
This Special Edition MLN Matters® article provides clarification of Federal guidance related to physician delegation of certain tasks in SNFs and NFs to Non-Physician Practitioners (NPPs). This article addresses the authority of Nurse Practitioners (NPs), Physician Assistants (PAs), or Clinical Nurse Specialists (CNSs) to perform certain tasks such as conducting physician visits, writing orders, and signing certifications and re-certifications.

Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c07.pdf
Chapter 7 is entitled "SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule" and provides information on this coverage. Further reference to this chapter is included under the Billing section of this pathway.

BILLING

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

Part A and Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections relevant to billing:

- 30.1.1.1: Charges to Hold a Bed During SNF Absence
- 40.1.3: Expiration and Renewal-Nonrenewal of SNF Term Agreements
- 40.4.1: Reviewing Inpatient Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions
- 40.4.2: Status of Hospital or SNF After Termination, Expiration, or Cancellation of Its Agreement
- 50.2.1: Inpatient Billing From Hospitals and SNFs
- 130.3.1: Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
- 130.3.2: SNF Inpatient Claim Adjustment Instructions
- 130.3.3: Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)
- 150.3: Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Search for SNF in Chapter 13, "Radiology Services and Other Diagnostic Procedures," to learn about the technical component of radiology services and other diagnostic billing.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Search for SNF in Chapter 16, "Laboratory Services," to learn more about billing for Part A and B SNF laboratory services including the following sections relating to SNF lab services:

- 40.4: Special Skilled Nursing Facility (SNF) Billing Exceptions for Laboratory Tests
- 40.4.1: Which A/B MAC (A) or (B) to Bill for Laboratory Services Furnished to a Medicare Beneficiary in a Skilled Nursing Facility (SNF)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Chapter 17, "Drugs and Biologicals," has information specifics to SNF billing. Search for SNF in this chapter.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," includes Section 160.2, "Special Considerations for SNF Billing for TPN and EN Under Part B."

More Resources: Refer to the Medicare Learning Network® booklet titled "Medicare Billing Information for Rural Providers and Suppliers" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html for more information regarding billing for rural services.

Chart – Skilled Nursing Facility Billing

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/downloads/3ruralchart.pdf
Although the web link mentions rural, this chart provides billing information helpful to all SNFs about billing Part A and Part B.

Part A

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," includes Section 10.4.3.2, "SNF Stay and End of Benefit Period."

- 10.3: Basis for Determining the Part A Coinsurance Amounts
- 10.4.1: Starting a Benefit Period
- 10.4.2: Ending a Benefit Period
- 10.4.3: Definition of Hospital or SNF for Ending a Benefit Period
- 10.4.3.2: SNF Stay and End of Benefit Period
- 10.4.4: Definition of Inpatient for Ending a Benefit Period
- 20.5.1: Part A Blood Deductible

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
Chapter 6 is entitled "SNF Inpatient Part A Billing and SNF Consolidated Billing" and includes the following sections regarding Part A billing:

- 10: Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

- 10.1: Consolidated Billing Requirement for SNFs
- 10.2: Types of Facilities Subject to the Consolidated Billing Requirement for SNFs
- 10.3: Types of Services Subject to the Consolidated Billing Requirement for SNFs
- 10.4: Furnishing Services that are Subject to SNF Consolidated Billing Under an “Arrangement” with an Outside Entity
- 10.4.1: “Under Arrangements” Relationships
- 10.4.2: SNF and Supplier Responsibilities
- 20: Services Included in Part A PPS Payment Not Billable Separately by the SNF
- 20.1: Services Beyond the Scope of the Part A SNF Benefit
- 20.1.1: Physician’s Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
- 20.1.1.1: Correct Place of Service (POS) Code for SNF Claims
- 20.1.1.2: Hospital’s “Facility Charge” in Connection with Clinic Services of a Physician
- 20.1.2: Other Excluded Services Beyond the Scope of a SNF Part A Benefit
- 20.1.2.1: Outpatient Surgery and Related Procedures– Inclusion
- 20.1.2.2: Emergency Services
- 20.2: Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election
- 20.2.1: Dialysis and Dialysis Related Services to a Beneficiary With ESRD
- 20.2.1.1: ESRD Services
- 20.2.1.2: Coding Applicable to Dialysis Services Provided in a Renal Dialysis Facility (RDF) or Home
- 20.2.2: Hospice Care for a Beneficiary’s Terminal Illness
- 20.3: Other Services Excluded from SNF PPS and Consolidated Billing
- 20.3.1: Ambulance Services
- 20.4: Screening and Preventive Services
- 20.5: Therapy Services
- 20.6: SNF CB Annual Update Process for A/B MACs (A)
- 30: Billing SNF PPS Services
- 30.1: Health Insurance Prospective Payment System (HIPPS) Rate Code
- 30.2: Coding PPS Bills for Ancillary Services
- 30.3: Adjustment Requests
- 30.4: SNF PPS Pricer Software
- 30.4.1: Input/Output Record Layout
- 30.4.2: SNF PPS Rate Components
- 30.4.3: Decision Logic Used by the Pricer on Claims
- 30.5: Annual Updates to the SNF Pricer
- 40: Special Inpatient Billing Instructions
- 40.1: Submit Bills in Sequence
- 40.2: Reprocessing Inpatient Bills in Sequence
- 40.3.1: Date of Admission
- 40.3.2: Patient Readmitted Within 30 Days After Discharge
- 40.3.3: Same Day Transfer
- 40.3.4: Situations that Require a Discharge or Leave of Absence
- 40.3.5: Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence
- 40.3.5.1: Day of Discharge or Death Is the Day Following the Close of the Accounting Year
- 40.3.5.2: Leave of Absence
- 40.4: Accommodation Charges Incurred in Different Accounting Years
- 40.5: Billing Procedures for Periodic Interim Payment (PIP) Method of Payment
- 40.6: Total and Noncovered Charges
- 40.6.1: Services in Excess of Covered Services

- 40.6.2: Showing Discounted Charges
- 40.6.3: Reporting Accommodations on the Claim
- 40.6.4: Bills with Covered and Noncovered Days
- 40.6.5: Notification of Limitation on Liability Decision
- 40.7: Ending a Benefit Period
- 40.8: Billing in Benefits Exhaust and No-Payment Situations
- 40.8.1: SNF Spell of Illness Quick Reference Chart
- 40.8.2: Billing When Qualifying Stay or Transfer Criteria are Not Met
- 40.9: Other Billing Situations
- 50: SNF Payment Bans, or Denial of Payment for New Admissions (DPNA)
- 50.1: Effect on Utilization Days and Benefit Period
- 50.2: Billing When Ban on Payment Is In Effect
- 50.2.1: Effect of an Appeal to a DPNA on Billing During the Period a SNF is Subject to a DPNA
- 50.2.2: Provider Liability Billing Instructions
- 50.2.3: Beneficiary Liability Billing Instructions
- 50.2.4: Part B Billing
- 50.3: Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period
- 50.3.1: Tracking the Benefit Period
- 50.3.2: Determining Whether Transfer Requirements Have Been Met
- 50.4: Conducting Resident Assessments
- 50.5: Physician Certification
- 50.6: A/B MAC (A) Responsibilities
- 50.7: Retroactive Removal of Sanctions
- 60: Billing Procedures for a Composite SNF or a Change in Provider Number
- 70.1: General Rules
- 70.2: Billing for Covered Services
- 70.3: Part B Billing
- 80: Billing Related to Physician's Services
- 80.1: Reassignment Limitations
- 80.2: Payment to Employer of Physician
- 80.3: Information Necessary to Permit Payment to a Facility
- 80.4: Services Furnished Within the SNF
- 80.5: Billing Under Arrangements
- 80.6: Indirect Contractual Arrangement
- 80.7: Establishing That a SNF Qualifies to Receive Part B Payment on the Basis of Reassignment
- 90: Medicare Advantage (MA) Beneficiaries
- 90.1: Beneficiaries Disenrolled from MA Plans
- 90.2: Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans
- 100: Part A SNF PPS for Hospital Swing Bed Facilities
- 100.1: Swing Bed Services Not Included in the Part A PPS Rate

Webpage – Skilled Nursing Facility PPS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html
This webpage provides an overview to the SNF PPS. The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

Webpage – Skilled Nursing Facility PPS – Education & Training

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Education.html
This webpage provides links to many educational resources about SNF PPS billing.

Webpage – Skilled Nursing Facility PPS – List of SNF Federal Regulations

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html
This webpage lists Federal Regulations related to the PPS and Consolidated Billing for SNFs.

Webpage – Skilled Nursing Facility PPS – SNF Program Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SNF-Program-Transmittals.html
This webpage shows transmittals that are directed to the SNF PPS provider community, but the list may not include all instructions for which SNF PPS providers are responsible. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Fact Sheet – Skilled Nursing Facility (SNF) Billing Reference

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244978.html
Learn about SNF coverage; payment; and billing requirements.

SNF Consolidated Billing

Webpage – Skilled Nursing Facility PPS – Consolidated Billing

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html
This webpage provides background information on SNF Consolidated Billing (CB).

Webpage – SNF Consolidated Billing

https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html
This overview page provides background on SNF CB. To find codes subject to consolidated billing, click on the appropriate file on the left side of the page (for year and Medicare Contractor).

Web-Based Training – "Skilled Nursing Facility Consolidated Billing"

https://learner.mlnlms.com/
This WBT course is designed to provide education for providers, suppliers, and other health care professionals about Skilled Nursing Facility (SNF) Consolidated Billing requirements. It includes payment information for the majority of services provided to beneficiaries in a Medicare-covered SNF stay, including most services provided by entities other than the SNF. It also includes information on bundled prospective payments made through the Medicare Administrative Contractor (A/B MAC) to the SNF.

IOM – "Medicare Claims Processing Manual," Pub.100-04, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c07.pdf
Chapter 7 is entitled "SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)" and includes the following sections:

- 10: Billing for Medical and Other Health Services
- 10.1: Billing for Inpatient SNF Services Paid Under Part B
- 10.1.1: Editing of Skilled Nursing Facilities Part B Inpatient Services
- 10.2: Billing for Outpatient SNF Services
- 10.3: Determining How Much to Charge Before Billing Is Submitted
- 10.4: Charges for Services Provided in Different Accounting Years
- 10.5: General Payment Rules and Application of Part B Deductible and Coinsurance
- 20: Use of Healthcare Common Procedure Coding System (HCPCS)
- 30: Billing Formats
- 30.1: Frequency of Billing for Skilled Nursing Facilities (SNFs)

- 30.2: Guidelines for Submitting Corrected Bills
- 40: Billing Part B Rehabilitation Services
- 40.1: Audiologic Tests
- 50: Billing Part B Radiology Services and Other Diagnostic Procedures
- 50.1: Bone Mass Measurements
- 60: Billing for Durable Medical Equipment (DME), Orthotic/Prosthetic Devices, and Supplies (including Surgical Dressings)
- 60.1: Billing
- 60.2: Determining Payment and Patient Liability
- 60.3: Billing for Enteral and Parenteral Nutritional Therapy as a Prosthetic Device
- 70: Drugs
- 70.1: Immunosuppressive Drugs Furnished to Transplant Patients
- 80: Screening and Preventive Services
- 80.1: Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
- 80.2: Mammography Screening
- 80.2.1: Diagnostic and Screening Mammograms Performed With New Technologies
- 80.3: Screening Pap Smears
- 80.4: Screening Pelvic Examinations
- 80.5: Prostate Cancer Screening
- 80.6: Colorectal Cancer Screening
- 80.7: Glaucoma Screening
- 90: Billing for Laboratory Tests Under Part B – General
- 90.1: Glucose Monitoring
- 100: Epoetin (EPO)
- 110: Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Search for SNF in Chapter 18, "Preventive and Screening Services," to learn about SNF mammography and vaccine billing.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes information specific to SNFs such as ambulatory blood pressure monitoring and electrical stimulation. Search for SNF in this chapter.

CLAIMS PROCESSING AND PAYMENT

PART A

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
Chapter 6 is entitled "SNF Inpatient Part A Billing and SNF Consolidated Billing" and includes the following sections regarding Part A claims processing and payment:

- 100: Part A SNF PPS for Hospital Swing Bed Facilities
- 100.1: Swing Bed Services Not Included in the Part A PPS Rate

- 110: A/B MAC (B)/DME MAC Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a SNF Part A Stay
- 110.1: Correct Place of Service (POS) Code for SNF Claims
- 110.2.1: Reject and Unsolicited Response Edits
- 110.2.2: A/B Crossover Edits
- 110.2.3: Duplicate Edits
- 110.2.4: Edit for Ambulance Services
- 110.2.5: Edit for Clinical Social Workers (CSWs)
- 110.2.6: Edit for Therapy Services Separately Payable When Furnished by a Physician
- 110.2.7: Edit to Prevent Payment of Facility Fees for Services Billed by an Ambulatory Surgical Center (ASC) when Rendered to a Beneficiary in a Part A Stay
- 110.3: CWF Override Codes
- 110.4: Coding Files and Updates
- 110.4.1: Annual Update Process

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 28

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 28, "Prospective Payments," includes information relevant to SNFs, such as:

- Calculating payment under SNF PPS
- Use of SNF PRICER
- SNF PPS – payment requirements and adjustments
- Reporting rehabilitative therapy minutes on the Minimum Data Set (MDS) for purposes of Medicare payment

Paper-Based Manual – "The Provider Reimbursement Manual-Part 2," Pub. 15-2, Chapters 13, 16, 35, and 41

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapters 13, 16, 35, and 41 include the following information:

- SNF Form CMS-2540-86
- SNF Form CMS-2540-92 instructions
- SNF Form CMS-2540-96 instructions and specification
- SNF Form CMS 2540-10 instructions and specifications

Webpage – Skilled Nursing Facility PPS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html
The SNF PPS webpage offers an overview of SNF PPS. The left of the page provides links to a Spotlight page where recent news is listed, a SNF Federal Regulations page, and also a SNF Program Transmittals webpage.

Webpage – PC Pricer – Skilled Nursing Facilities (SNF PPS) PC Pricer

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/SNF.html
This webpage provides information on the "SNF PC Pricer User's Manual," giving detailed instructions for the use of PC Pricer software, including field definitions, claims entry instructions, and sample screens and reports.

Booklet – "Skilled Nursing Facility Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
This booklet is designed to provide education on the Skilled Nursing Facility Prospective Payment System (SNF PPS). It includes the following information: background, elements of the SNF PPS, SNF Quality Reporting Program, and SNF Value-Based Purchasing Program.

MLN Matters® Article – MM8044 "Manual Updates to Clarify Skilled Nursing Facility (SNF) Claims Processing"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8044.pdf
This MLN Matters® article provides policy clarifications pertaining to the SNF consolidated billing provision and claims processing,

Part A Therapy

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," includes information relevant to Part A SNFs and therapy.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to situations under which educational services may or may not be covered in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also identify LCDs by Medicare Contractors.

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//ncd103c1_Part3.pdf
- 170.1: Institutional and Home Care Patient Education Programs

MLN Matters® Article – SE1024 Revised "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1024.pdf
This Special Edition MLN Matters® article is for all inpatient hospital and SNF providers that submit Fee-For-Service (FFS) Medicare claims.

Part B

IOM – "Medicare Claims Processing Manual," Pub.100-04, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c07.pdf
Chapter 7, "SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)," is addressed under Part B billing.

Therapy Billing

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," explains therapy benefits covered by the Medicare Program. Sections relevant to Outpatient Physical Therapy (OPT), Other Rehabilitation Facility (ORF), and Outpatient Speech Pathology (OSP) include:
- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-

Language Pathology Services) Under Medical Insurance
- 220.1: Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.1: Care of a Physician/Nonphysician Practitioner (NPP)
- 220.1.2: Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 220.1.4: Requirement That Services Be Furnished on an Outpatient Basis
- 220.2: Reasonable and Necessary Outpatient Rehabilitation Therapy Services
- 220.3: Documentation Requirements for Therapy Services
- 220.4: Functional Reporting
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology
- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about therapy billing:
- 10.3: Application of Financial Limitations
- 20.1: Discipline Specific Outpatient Rehabilitation Modifiers – All Claims
- 20.2: Reporting of Service Units With HCPCS
- 20.3: Determining What Time Counts Towards 15-Minute Timed Codes – All Claims
- 20.4: Coding Guidance for Certain CPT Codes – All Claims
- 40.2: Applicable Types of Bill
- 40.3: Applicable Revenue Codes
- 40.4: Edit Requirements for Revenue Codes
- 40.5: Line Item Date of Service Reporting
- 40.6: Non-covered Charge Reporting
- 50: CWF and PS&R Requirements – A/B MAC (A)

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 14, "Reasonable Cost of Therapy and Other Services," includes information relevant to outpatient therapy services.

Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
This webpage provides helpful information on therapy payment caps, billing scenarios, and therapy updates.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

Electronic Mailing List – Therapy-Caps

https://list.nih.gov/cgi-bin/wa.exe?A0=THERAPY-CAPS-L

The therapy caps electronic mailing list is administered by CMS, which emails subscribers information regarding therapy caps.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about outpatient therapy services. Use the search feature on the home page of this website to review these.

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

MLN Matters® Article – MM7050 Revised "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf
This MLN Matters® article provides information on the MPPR)to the Practice Expense (PE) component of payment of select therapy services paid under the Medicare Physician Fee Schedule (MPFS). Many therapy services are time-based codes, meaning multiple units may be billed for a single procedure. CMS is applying an MPPR to the practice expense payment when more than one unit or procedure is provided to the same beneficiary on the same day, meaning the MPPR applies to multiple units as well as multiple procedures.

MLN Matters® Article – MM8036 Revised "Manual Medical Review of Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8036.pdf
This MLN Matters® article discusses requirements for requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance.

MLN Matters® Article – MM9448 "Therapy Cap Values for Calendar Year (CY) 2016"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9448.pdf
This MLN Matters® article describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for CY 2016.

BENEFICIARY NOTICES

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)," has information of interest to SNFs regarding beneficiary notices and Quality Improvement Organization (QIO) expedited review.

Webpage – Beneficiary Notices Initiative (BNI) – FFS SNFABN and SNF Denial Letters

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSSNFABNandSNFDenialLetters.html
This webpage includes links to download SNF Advance Beneficiary Notices (ABNs) and denial letters with accompanying instructions.

Webpage – Beneficiary Notices Initiative (BNI) – FFS ED Notices

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
This webpage explains SNF use of the expedited notices, Form CMS-10123 and CMS-10124, and provides links to these notices in English and Spanish.

Form – Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) Form CMS-10055

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/CMS10055.pdf
This form is used to notify beneficiaries who are residents of a SNF that services are not covered under Medicare.

Form – Notice of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF) Form CMS-20014

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/CMS20014.pdf
The Notice of Exclusion from Medicare Benefits Skilled Nursing Facility (NEMB SNF) form may be used with extended care item(s) and service(s) that are not Medicare benefits. NEMB-SNFs alert Medicare beneficiaries in advance that Medicare does not cover certain extended care item(s) and/or service(s) because the item or service does not meet the definition of a Medicare benefit or because the item or service has been specifically excluded by law.

QUALITY

Webpage – Nursing Home Quality Initiative

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html
This webpage provides consumer and provider information on the quality of care in nursing homes. The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay. These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their residents' physical and clinical needs.

Webpage – Nursing Home Compare

https://www.medicare.gov/nursinghomecompare/search.html
From this webpage, the Nursing Home Compare tool provides public access to nursing home characteristics, staffing, and quality of care measures for certified nursing homes.

Webpage – Survey & Certification – Certification & Compliance – Five-Star Quality Rating System

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html
This webpage explains that CMS created the Five-Star Quality Rating System to help beneficiaries, their families, and caregivers compare nursing homes more easily and to help identify areas about which consumers may have questions. The Nursing Home Compare website features a quality rating system that gives each nursing home a rating of between one and five stars.

Website – Advancing Excellence in America's Nursing Homes Campaign

http://www.nhqualitycampaign.org
This website explains the goal of the campaign is to help nursing homes achieve excellence in the quality of care and quality of life for nursing home residents.

RAI and MDS (Part A Medicare Only)

Webpage – Nursing Home Quality Initiative – MDS 3.0 RAI Manual

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
The Downloads section of this webpage contains the current version of the MDS 3.0 RAI Manual.

MDS

Webpage – Nursing Home Quality Initiative – MDS 3.0 for Nursing Homes and Swing Bed Providers

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
The MDS is a powerful tool for standardized assessments and for tracking care management in Nursing Homes (NHs) and non-Critical Access Hospital (CAH) Swing Beds (SBs). This webpage explains that Minimum Data Set (MDS) 3.0 replaced 2.0 on October 1, 2010. MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings.

Webpage – Minimum Data Sets 2.0 Tool and Public Reports

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MinimumDataSets20/index.html
This webpage provides technical information related to the MDS version 2.0 RAI. This MDS was retired September 30, 2010. At this time the information on this webpage remains on the CMS website as a historical reference for providers.

Resident Assessment Instrument (RAI)

IOM – "Quality Improvement Organization Manual," Pub. 100-10, Chapters 1, 4, and 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c01.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c05.pdf
Chapter 1, "Background and Responsibilities," Chapter 4, "Case Review," and Chapter 5, "Quality of Care Review," include references to SNFs.

OTHER RESOURCES

Other helpful, official resources are included in this section.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following sections relevant to SNFs:

- 6.1: Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills
- 6.1.1: Types of SNF PPS Review

- 6.1.2: Bill Review Requirements
- 6.1.3: Bill Review Process
- 6.1.4: Workload
- 6.1.5: SNF RUG-III Adjustment Matrices and Outcomes Historical Exhibit
- 6.3: Medical Review of Certification and Recertification of Residents in SNFs

Website – Office of Inspector General, U.S. Department of Health & Human Services

https://oig.hhs.gov
The OIG has issued reports about SNFs. Use the search feature on the home page of this website to review these.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term SNF for related questions and answers. For example, FAQ2933 addresses SNFs in a DMEPOS Competitive Bidding Area.

Webpage – Open Door Forums – Skilled Nursing Facilities/Long-Term Care Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_SNFLTC.html
This webpage provides information on opportunities for live dialogue between CMS and SNFs.

Electronic Mailing List – SNF

https://list.nih.gov/cgi-bin/wa.exe?A0=SNF-L
The SNF electronic mailing list is administered by CMS, which emails subscribers information regarding SNF policy, publications, coding, payment, and educational material.

Toolkit – "CMS Hand in Hand: A Training Series for Nursing Homes Toolkit"

http://www.cms-handinhandtoolkit.info/Index.aspx
Hand in Hand is a high quality training series for nursing homes that emphasizes person-centered care for persons with dementia, as well as the prevention of abuse. Hand in Hand addresses the annual requirement for nurse aide training on these important topics. While annual training for nurse aides on dementia care and abuse prevention is required in current nursing home regulations, CMS does not require nursing homes to use the Hand in Hand training specifically. Other tools and resources are also available.

Beneficiary Booklet – "Your Guide to Choosing a Nursing Home"

https://www.medicare.gov/Publications/Search/results.asp?PubID=02174&PubLanguage=1&Type=PubID
The booklet contains detailed information on choosing a nursing home, as well as costs and coverage.

Beneficiary Brochure – "Medicare & Skilled Nursing Facility Care Benefits: Getting Started"

https://www.medicare.gov/Pubs/pdf/11359.pdf
This brochure explains the basics of Medicare's SNF benefits.

Beneficiary Brochure – "Medicare Coverage of Skilled Nursing Facility Care"

https://www.medicare.gov/Publications/Search/results.asp?PubID=10153&PubLanguage=1&Type=PubID
This brochure explains Medicare-covered skilled care, beneficiary rights and protections, and where beneficiaries can get help with their questions.

Beneficiary Fact Sheet – "Medicare Limits on Therapy Services"

https://www.medicare.gov/Pubs/pdf/10988.pdf

This fact sheet explains the therapy cap limits for outpatient physical therapy, speech-language pathology, and occupational therapy.

HOSPITALS

INTRODUCTION

This curriculum is designed as a pathway to Hospital resources.

DEFINITION: HOSPITAL

A hospital (other than psychiatric) means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Outpatient services are optional.

Webpage – Hospital Center

https://www.cms.gov/Center/Provider-Type/Hospital-Center.html
The Hospital Center contains helpful links to billing/payment, coverage, Centers for Medicare & Medicaid Services (CMS) manuals and transmittals, policies/regulations, contacts, and educational resources for hospitals. This webpage also includes a Spotlights section for new information, as well as links to Special Topics.

For additional information regarding hospital services for Medicare beneficiaries, refer to pathways for the following hospitals/units, which have separate certification requirements and Medicare payment systems:

- Critical Access Hospital (CAH)
- Long Term Care Hospital (LTCH)
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Psychiatric Facility (IPF)
- Religious Nonmedical Health Care Institution (RNHCI)

Booklet – "Discharge Planning"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908184.html
This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

More Resources: Refer to the Ambulance Service Provider and Supplier, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), End-Stage Renal Disease (ESRD) Facility, and Laboratory pathways for additional information related to hospitals.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 10, "Provider and Related Definitions," which has several specific references

to hospital requirements, including information about the required provider agreement, which must be signed before participating in Medicare. Search for hospital in this section.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.8, "Hospitals and Hospital Units," which has information about multi-campus and subpart enrollment.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 20.4, "Certification of Parts of Institutions as Hospital."

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
Chapter 11, "End Stage Renal Disease (ESRD)," includes Section 140.18, "Hospitals that Excise but Do Not Transplant Kidneys," which contains certification information for hospitals that perform kidney excisions.

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1 "Program Background and Responsibilities," includes Section 1000A, "Medicare Provisions," and Section 1018C, "Deemed Providers/Suppliers (Excluding CLIA Laboratories)."

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes a section entitled "Hospitals," comprised of the following sections:

- 2020: Hospitals – Definition and Citations
- 2021A: Recertification of Non-deemed Hospitals
- 2022: Deemed Status: Hospitals Accredited by an Accrediting Organization with a CMS-approved Medicare Hospital or Medicare Psychiatric Hospital Accreditation Program
- 2022A: Notice that a Participating Hospital has Been Accredited and Recommended for Deemed Status
- 2022B: Recertification
- 2022C: Notification of Withdrawl or Loss of Deemed Status Accreditation
- 2024: Hospital Merger/Multiple Campus Criteria
- 2026A: Hospitals (Other Than Psychiatric Hospitals)
- 2026B: Excluded Non-Service Units May be Appropriate
- 2030: Temporary Waivers Applicable to Rural Hospitals
- 2034: Time Limit on Temporary Waiver
- 2036: Definition, Authority and Requirements for Hospital Providers of Extended Care Services ("Swing-Beds")
- 2037A: Request from a Medicare Participating Hospital to Add Swing-Bed Approval
- 2037B: Screening
- 2037C: Provider Agreement
- 2037D: Calculation of Bed Count
- 2037E: Rural Area
- 2037F: Certificate Of Need (CON) Approval
- 2052A: Emergency Hospital Services
- 2052B: Preparation of Initial Certification
- 2052C: Recertification and Follow-Up

IOM – "State Operations Manual," Pub. 100-07, Appendix A

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors.

IOM – "State Operations Manual," Pub. 100-07, Appendix V

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf
Appendix V, "Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors.

Webpage – Survey & Certification – General Information – Accreditation of Medicare Certified Providers & Suppliers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html
This webpage provides information on Accreditation Organizations (AOs) and a list of organizations qualified to provide accreditation to hospitals enrolled in the Medicare Program.

Webpage – Survey & Certification – Certification & Compliance – Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html
This webpage provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, such as Emergency Medical Treatment & Labor Act (EMTALA) and other certification pages.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Hospitals

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals.html
This webpage provides information about the Federal regulations which contain the minimum health and safety requirements that hospitals must meet to participate in the Medicare and Medicaid Programs. In addition, there are links to the Final Patient Rights Rule, the Social Security Law, and other related webpages.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Hospitals.html
This webpage explains that survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of survey findings. This webpage provides links to other related resources.

Transmittal – 81 "Revisions to State Operations Manual (SOM), Appendix A, Hospitals"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81SOMA.pdf
This transmittal covers information on who may provide certain services in a hospital.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections:

- 20: Hospital Defined
- 20.1: Definition of Emergency Inpatient and Outpatient Services
- 20.2: Definition of an Emergency Services Hospital

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf
Chapter 2, "Admission and Registration Requirements," includes the following sections relevant to coverage:

- 10.5: Hospital and Skilled Nursing Facility (SNF) Verification of Prior Hospital Stay Information for Determining Deductible and Benefit Period Status
- 10.6: Hospitals May Require Prepayment for Noncovered Services
- 10.8: Request for Payment Should Be Obtained in All Cases as Protective Application for Hospital Insurance Benefits
- 10.12: SNF Verification of Prior Hospital Stay and Transfer Requirements
- 90: Outpatient Hospital Registration Procedures

Webpage – Medicare Approved Facilities/Trials/Registries

https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html
This webpage provides information regarding Medicare certification of facilities performing the following procedures: carotid artery stenting, Ventricular Assist Device (VAD) destination therapy, bariatric surgery, certain oncologic Positron Emission Tomography (PET) scans in Medicare-specified studies, and lung volume reduction surgery.

MLN Matters® Article – SE1210 "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1210.pdf
This Special Edition MLN Matters® article is intended for hospitals that bill Medicare Administrative Contractors for renal and urinary tract disorders in Medicare beneficiaries.

INPATIENT/PART A

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes the following sections about physician certifications for inpatient hospital services to beneficiaries:

- 10: Certification and Recertification by Physicians for Hospital Services – General
- 10.1: Failure to Certify or Recertify for Hospital Services
- 10.2: Who May Sign Certification or Recertification
- 10.3: Certification for Hospital Admissions for Dental Services
- 10.4: Inpatient Hospital Services Certification and Recertification
- 10.5: Selection by Hospital of Format and Method for Obtaining Statement
- 10.6: Criteria for Continued Inpatient Hospital Stay
- 10.7: Utilization Review (UR) in Lieu of Separate Recertification Statement
- 10.8: Timing of Certifications and Recertifications
- 10.8.1: Admissions on or After January 1, 1970 for Non-PPS Hospitals

- 10.8.2: Patients Discharged During Hospital Fiscal Years Beginning on or After October 1, 1983 Under PPS
- 20: Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
- 20.1: Delayed Certifications and Recertifications
- 20.2: Timing for Certification and Recertification for A Beneficiary Admitted Before Entitlement

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//bp102c01.pdf

Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes the following sections about Part A hospital coverage:

- 1: Definition of Inpatient Hospital Services
- 10: Covered Inpatient Hospital Services Covered Under Part A
- 10.1: Bed and Board
- 10.1.1: Accommodations – General
- 10.1.2: Medical Necessity – Need for Isolation
- 10.1.3: Medical Necessity – Admission Required and Only Private Rooms Available
- 10.1.4: Charges for Deluxe Private Room
- 10.1.5: All Private Room Providers
- 10.1.6: Wards
- 10.1.6.1: Assignment Consistent With Program Purposes
- 10.1.6.2: Assignment Not Consistent With Program Purposes
- 10.1.7: Charges
- 20: Nursing and Other Services
- 20.1: Anesthetist Services
- 20.2: Medical Social Services to Meet the Patient's Medically Related Social Needs
- 30: Drugs and Biologicals
- 30.1: Drugs Included in the Drug Compendia
- 30.2: Approval by Pharmacy and Drug Therapeutics Committee
- 30.3: Combination Drugs
- 30.4: Drugs Specially Ordered for Inpatients
- 30.5: Drugs for Use Outside the Hospital
- 40: Supplies, Appliances, and Equipment
- 50: Other Diagnostic or Therapeutic Items or Services
- 50.1: Therapeutic Items
- 50.2: Diagnostic Services of Psychologists and Physical Therapists
- 50.3: Diagnostic Services Furnished to an Inpatient by an Independent Clinical Laboratory Under Arrangements With the Hospital
- 50.4: Diagnostic Services Furnished a Hospital Inpatient Under Arrangement With the Laboratory of Another Participating Hospital
- 60: Services of Interns or Residents-In-Training
- 70: Inpatient Services in Connection With Dental Services
- 80: Health Care Associated With Pregnancy
- 90: Termination of Pregnancy
- 100: Treatment for Infertility

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c03.pdf

Chapter 3, "Duration of Covered Inpatient Services," includes the following sections relevant to coverage:

- 10: Benefit Period (Spell of Illness)
- 20: Inpatient Benefit Days
- 20.1: Counting Inpatient Days
- 20.1.1: Late Discharge

- 20.1.2: Leave of Absence
- 20.1.3: Discharge or Death on First Day of Entitlement or Participation
- 30: Inpatient Days Counting Toward Benefit Maximums

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf
Chapter 5, "Lifetime Reserve Days," includes the following sections:

- 10: Summary of Provision
- 10.1: Effect of Reserve Days on Guarantee of Payment Provision
- 10.2: Reserve Days Not Available Where Average Charges Do Not Exceed One-Half Inpatient Hospital Deductible
- 10.3: Availability of Reserve Days Where Psychiatric Limitations Are Involved
- 10.4: Availability of Reserve Days for Hospital Emergency Services
- 10.5: Physician Certification
- 20: When Payment Will Be Made for Reserve Days
- 30: Election Not to Use Lifetime Reserve Days
- 30.1: General
- 30.2: Election Made Prospectively
- 30.3: Retroactive Election
- 30.4: Period Covered by Election
- 30.4.1: Hospitals Not Reimbursed Under Prospective Payment System
- 30.4.2: Hospitals Reimbursed Under Prospective Payment System
- 30.4.2.1: Beneficiary Has One or More Regular Benefit Days Available at Time of Admission to PPS Hospital – Discharge Before October 1, 1997
- 30.4.2.2: Beneficiary Has No Regular Days Available at Time of Admission – Discharge Before October 1, 1997
- 30.5: Election Where Beneficiary Is Incapacitated
- 30.6: Lifetime Reserve Days and Long Term Care Hospital (LTCH) Prospective Payment System (PPS)
- 40: Content of Election
- 40.1: Election Format
- 40.2: Revocation of Election
- 40.2.1: Revocation Format

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
Chapter 16, "General Exclusions from Coverage," includes the following sections relevant to hospitals:

- 10: General Exclusions From Coverage
- 40.4: Items Covered Under Warranty
- 50.1.1: Veterans' Administration (VA) Authorized Services
- 50.1.3: Effect of VA Payments on Medicare Deductible and Utilization
- 50.1.5: Services Authorized by Indian Health Service
- 50.2: Items and Services Furnished by Federal Provider of Services or Federal Agency
- 50.3.1: Application of Exclusion to State and Local Government Providers
- 50.3.3: Examples of Application of Government Entity Exclusion
- 170: Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider
- 180: Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to hospitals in the title of a specific NCD. (Outpatient references are listed in the Outpatient section of this pathway.) There might be other NCDs of interest in this manual.

NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf

- 10.2: Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain
- 10.3: Inpatient Hospital Pain Rehabilitation Programs
- 20.7: Percutaneous Transluminal Angioplasty (PTA)
- 20.8.3: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers
- 20.32: Transcatheter Aortic Valve Replacement (TAVR)
- 30.2: Thermogenic Therapy
- 30.7: Laetrile and Related Substances
- 40.3: Closed-Loop Blood Glucose Control Device (CBGCD)
- 70: Evaluation and Management of Patient - Office/hospital/home
- 70.5: Hospital and Skilled Nursing Facility Admission Diagnostic Procedures
- 80.12: Intraocular Lenses (IOLs)

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf

- 110.2: Certain Drugs Distributed by the National Cancer Institute
- 110.7: Blood Transfusions
- 110.14: Apheresis (Therapeutic Pheresis)
- 110.20: Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors
- 130.1: Inpatient Hospital Stays for the Treatment of Alcoholism
- 130.3: Chemical Aversion Therapy for Treatment of Alcholism
- 130.6: Treatment of Drug Abuse (Chemical Dependency)
- 160.12: Neuromuscular Electrical Stimulator (NMES)
- 160.17: L-Dopa

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf

- 210.4: Smoking and Tobacco - Use Cessation Counseling
- 210.4.1: Counseling to Prevent Tobacco use (Effective August 25, 2010)
- 210.8: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- 210.9: Screening for Depression in Adults (Effective October 14, 2011)
- 210.11: Intensive Behavior Therapy for Cardiovascular Disease (CVD) (Effective November 8, 2011)
- 210.12: Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)
- 210.13: Screening for Hepatitis C Virus (HCV) in Adults
- 220.1: Computed Tomography (CT)
- 220.9: Digital Subtraction Angiography (DSA)
- 240.7: Postural Drainage Procedures and Pulmonary Exercises

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf

Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following information about medical review of inpatient claims:

- 6.5: Medical Review of Inpatient Hospital Claims
- 6.5.1: Screening Instruments
- 6.5.2: Medical Review of Inpatient Prospective Payment System (IPPS) Hospital and Long Term Care Hospital (LTCH) Claims

- 6.5.3: DRG Validation Review
- 6.5.4: Review of Procedures Affecting the DRG
- 6.5.5: Special Review Considerations
- 6.5.6: Length-of-Stay Review
- 6.5.9: Circumvention of PPS

Fact Sheet – "The DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243495.html
Learn about an exception to regular program rules for walkers provided by hospitals that are not contract suppliers; requirements to meet the exception; and payment rules under this exception

MLN Matters® Article – SE1037 Revised "Guidance on Hospital Inpatient Admission Decisions"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf
This Special Edition MLN Matters® article provides CMS assistance to hospitals in making inpatient admission decisions.

Outpatient/Part B

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," defines outpatient hospital services such as emergency and outpatient services.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes a definition of outpatient as part of its clarification of inpatient services.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf
Chapter 6, "Hospital Services Covered Under Part B," includes the following sections relevant to Part B coverage:

- 10: Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
- 20: Outpatient Hospital Services
- 20.1: Limitation on Coverage of Certain Services Furnished to Hospital Outpatients
- 20.1.1: General Rule
- 20.1.2: Exception to Limitation
- 20.2: Outpatient Defined
- 20.3: Encounter Defined
- 20.4: Outpatient Diagnostic Services
- 20.4.1: Diagnostic Services Defined
- 20.4.3: Coverage of Outpatient Diagnostic Services Furnished on or Before December 31, 2009
- 20.4.4: Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010
- 20.4.5: Outpatient Diagnostic Services Under Arrangements

- 20.5: Outpatient Therapeutic Services
- 20.5.1: Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After August 1, 2000, and Before January 1, 2010
- 20.5.2: Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010
- 20.6: Outpatient Observation Services
- 20.7: Non-Surgical Extended Duration Therapeutic Services
- 30: Drugs and Biologicals
- 40: Other Covered Services and Items
- 50: Sleep Disorder Clinics
- 60: Intermittent Peritoneal Dialysis Services
- 70: Outpatient Hospital Psychiatric Services
- 70.1: General
- 70.2: Coverage Criteria for Outpatient Hospital Psychiatric Services
- 70.3: Partial Hospitalization Services
- 70.5: Laboratory Services Furnished to Nonhospital Patients by Hospital Laboratory
- 80: Rental and Purchase of Durable Medical Equipment
- 90: Services of Interns And Residents

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Chapter 15, "Covered Medical and Other Health Services," includes information on therapy services provided in the outpatient setting, as well as the following sections about Part B coverage:

- 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
- 220.1: Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.1: Care of a Physician/Nonphysician Practitioner (NPP)
- 220.1.2: Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 220.1.4: Requirement That Services Be Furnished on an Outpatient Basis
- 220.2: Reasonable and Necessary Outpatient Rehabilitation Therapy Services
- 220.3: Documentation Requirements for Therapy Services
- 220.4: Functional Reporting
- 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
- 230.1: Practice of Physical Therapy
- 230.2: Practice of Occupational Therapy
- 230.3: Practice of Speech-Language Pathology
- 230.6: Therapy Services Furnished Under Arrangements With Providers and Clinics
- 250: Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html

Chapter 1, "Coverage Determinations," includes reference to hospitals in the title of a specific NCD and is relevant to Part B coverage. There might be other NCDs of interest in this manual. NCDs may also be found by using the Searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include LCDs by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part1.pdf
- 10.4: Outpatient Hospital Pain Rehabilitation Programs
- 70: Evaluation and Management of Patients – Office/hospital/home

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf
- 130.2: Outpatient Hospital Services for Treatment of Alcoholism
- 130.6: Treatment of Drug Abuse (Chemical Dependency)
- 160.12: Neuromuscular Electrical Stimulator (NMES)

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. it includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

Fact Sheet – "Provider Compliance Tips for Computed Tomography (CT Scans)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907793.html
This fact sheet is designed to provide education on CT Scans. It includes helpful tips on how to prevent claim denials as well as documentation needed to submit a claim.

Podcast – "Provider Compliance Tips for Computed Tomography (CT) Scans"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2014-12-15-Provider-Compliance.html
This podcast is designed to provide education on CT Scans. It includes helpful tips on how to prevent claim denials as well as documentation needed to submit a claim.

BILLING

Inpatient/Part A

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf
Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations," provides information on inpatient hospital deductible and coinsurance information, as well as inpatient services.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," provides the following information about hospital inpatient billing:
- 50.2: Frequency of Billing for Providers
- 50.2.1: Inpatient Billing From Hospitals and SNFs
- 50.2.3: Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment
- 50.2.4: Reprocess Inpatient or Hospice Claims in Sequence
- 50.3: When an Inpatient Admission May Be Changed to Outpatient Status

- 50.3.1: Background
- 50.3.2: Policy and Billing Instructions for Condition Code 44
- 60.1.3: Claims with Condition Code 21
- 60.2: Noncovered Charges on Inpatient Bills
- 60.2.1: Billing for Noncovered Procedures in an Inpatient Stay
- 60.3: Noncovered Charges on Institutional Demand Bills
- 60.3.1: Background on Institutional Demand Bills (Condition Code 20)
- 60.3.2: Inpatient and Outpatient Demand Billing Instructions
- 130.2: Inpatient Part A Hospital Adjustment Bills
- 130.2.1: Tolerance Guidelines for Submitting Inpatient Part A Hospital Adjustment Requests
- 130.4: Hospital and SNF Part B Adjustment Requests
- 130.4.1: Guidelines for Submitting Adjustment Requests
- 140.2: Systematic Validation of Claims Information Using Patient Assessments

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

Chapter 3, "Inpatient Hospital Billing," has the following sections relevant to Part A billing:

- 10: General Inpatient Requirements
- 10.1: Claim Formats
- 10.3: Spell of Illness
- 10.5: Hospital Inpatient Bundling
- 20.1.2.4: Transfers
- 20.7: Billing Applicable to PPS
- 20.7.1: Stays Prior to and Discharge After IPPS Implementation Date
- 20.7.2: Split Bills
- 20.7.4: Cost Outlier Bills With Benefits Exhausted
- 40: Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals
- 40.1: "Day Count" Rules for All Providers
- 40.2: Determining Covered/Noncovered Days and Charges
- 40.2.1: Noncovered Admission Followed by Covered Level of Care
- 40.2.4: IPPS Transfers Between Hospitals
- 40.2.5: Repeat Admissions
- 40.2.6: Leave of Absence
- 40.3: Outpatient Services Treated as Inpatient Services
- 40.3.1: Billing Procedures to Avoid Duplicate Payments
- 50: Adjustment Bills
- 50.1: Tolerance Guidelines for Submitting Adjustment Requests
- 50.2: Claim Change Reasons
- 50.3: Late Charges
- 70: All-Inclusive Rate Providers
- 70.1: Providers Using All-Inclusive Rates for Inpatient Part A Charges
- 80: Hospitals That Do Not Charge

- 90: Billing Transplant Services
- 100: Billing Instructions for Specific Situations
- 100.1: Billing for Abortion Services
- 100.3: Resident and Interns Not Under Approved Teaching Programs
- 100.4: Billing for Services After Termination of Provider Agreement
- 100.4.1: Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number
- 100.5: Review of Hospital Admissions of Patients Who Have Elected Hospice Care
- 100.6: Inpatient Renal Services
- 100.7: Lung Volume Reduction Surgery
- 100.8: Replaced Devices Offered Without Cost or With a Credit

IOM – "Medicare Secondary Payer Manual," Pub. 100-05, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c05.pdf
Chapter 5, "Contractor Prepayment Processing Requirements," includes several references to hospitals, such as identification of where further development is not necessary and information about occurrence codes.

Webpage – Hospital-Acquired Conditions (Present on Admission Indicator)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html
This webpage discusses the conditions that are selected for the Hospital-Acquired Conditions (HAC) payment provision.

Webpage – ICD-10 – 2015 ICD-10 PCS and GEMs

https://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html
The 2015 ICD-10 Procedure Coding System (ICD-10-PCS) files listed on this webpage contain information on the procedure coding system, ICD-10-PCS, that replaced ICD-9-CM, Volume 3.

Fact Sheet – "Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243355.html
Learn about the Hospital-Acquired Conditions and Present on Admission Indicator Reporting provision and exempt hospitals.

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

Podcast – "Post-Acute Care Transfer-Underpayments"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908998.html
This podcast is designed to provide education on Medicare claims underpayments in post-acute care transfer. It includes information on the importance of coding claims as transfers only if the beneficiary is discharged to another facility.

Podcast – "Recovery Audit Program Demonstration: High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/CMS1246789.html

This podcast is designed to provide education to inpatient hospital providers about CMS Recovery Audit Program (RAP) findings that contribute to improper Medicare payments. It includes information from MLN Matters Article #SE1028 and discusses some of the DRG coding findings identified by the RAP in an effort to prevent future improper payment issues.

Podcast – "Recovery Audit Program Demonstration: High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/CMS1245720.html
This podcast is designed to provide education to inpatient hospital providers about CMS Recovery Audit Program (RAP) findings that contribute to improper Medicare payments. It includes information from MLN Matters Article #SE1027 and discusses some of the 17 findings identified by the RAP in an effort to prevent future improper payment issues.

MLN Matters® Article – SE1024 Revised "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1024.pdf
This Special Edition MLN Matters® article is for all inpatient hospital and SNF providers that submit Fee-For-Service Medicare claims.

MLN Matters® Article – SE1027 "Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1027.pdf
This Special Edition MLN Matters® article advises inpatient hospitals about 17 RAC demonstration-identified medical necessity vulnerabilities.

MLN Matters® Article – SE1028 Revised "Recovery Audit Contractor (RAC) Demonstration High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1028.pdf
This Special Edition MLN Matters® article provides information about four RAC demonstration-identified inpatient hospital coding vulnerabilities.

MLN Matters® Article – SE1117 Revised "Correct Provider Billing of Admission Date and Statement Covers Period"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1117.pdf
This Special Edition MLN Matters® article explains that previously Medicare's Fiscal Intermediary Shared System (FISS) edits required that the Admission Date not be later than the 'From' date on initial provider claims as required to match National Uniform Billing Committee Uniform Billing (NUBC UB-92) definitions. In order to pass FISS edits and avoid getting a claim rejected, providers may have engineered workarounds that force the two dates to match. CMS has issued instructions to FISS for modifying FISS edits regarding these data elements to match NUBC UB-04 definitions.

MLN Matters® Article – SE1121 Revised "Recovery Audit Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1121.pdf

One of CMS' strategies to reduce the Comprehensive Error Rate Testing (CERT) error rate is to correct identified vulnerabilities discovered by the Recovery Auditors and other Medicare Contractors. Recovery Auditors have identified coding errors while performing DRG Validation review. DRG Validation review focuses on the hospital's selection of principal and secondary diagnoses and procedures on a claim.

MLN Matters® Article – MM9658 "July 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf
This MLN Matters® article describes changes to the OPPS implemented in the July 2016 update.

Outpatient/Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," provides the following information about hospital outpatient/Part B billing:

- 50.2.2: Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services
- 50.3: When an Inpatient Admission May Be Changed to Outpatient Status
- 50.3.1: Background
- 50.3.2: Policy and Billing Instructions for Condition Code 44
- 60.1.3: Claims with Condition Code 21
- 60.1.3.1: Provider-liable Fully Noncovered Outpatient Claims
- 60.2: Noncovered Charges on Inpatient Bills
- 60.3: Noncovered Charges on Institutional Demand Bills
- 60.3.1: Background on Institutional Demand Bills (Condition Code 20)
- 60.3.2: Inpatient and Outpatient Demand Billing Instructions
- 60.4: Noncovered Charges on Outpatient Bills
- 60.4.1: Outpatient Billing With an ABN (Occurrence Code 32)
- 60.4.2: Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes information on outpatient/Part B billing:

- 20: Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)
- 20.1: General
- 20.1.1: Elimination of 90-day Grace Period for HCPCS (Level I and Level II)
- 20.2: Applicability of OPPS to Specific HCPCS Codes
- 20.3: Line Item Dates of Service
- 20.4: Reporting of Service Units
- 20.5: Clarification of HCPCS Code to Revenue Code Reporting
- 20.6: Use of Modifiers
- 20.6.1: Where to Report Modifiers on the Hospital Part B Claim

- 20.6.2: Use of Modifiers -50, -LT, and –RT
- 20.6.3: Modifiers -LT and –RT
- 20.6.4: Use of Modifiers for Discontinued Services
- 20.6.5: Modifiers for Repeat Procedures
- 20.6.6: Modifiers for Radiology Services
- 20.6.7: CA Modifier
- 20.6.8: HCPCS Level II Modifiers
- 20.6.9: Use of HCPCS Modifier-FB
- 20.6.10: Use of HCPCS Modifier – FC
- 20.6.11: Use of HCPCS Modifier – PO
- 20.7: Billing of 'C' HCPCS Codes by Non-OPPS Providers
- 30: OPPS Coinsurance
- 30.1: Coinsurance Election
- 60: Billing for Devices Eligible for Transitional Pass-Through Payments and Items Classified in "New Technology" APCs
- 60.1: Categories for Use in Coding Devices Eligible for Transitional Pass- Through Payments Under the Hospital OPPS
- 60.2: Roles of Hospitals, Manufacturers, and CMS in Billing for Transitional Pass-Through Items
- 60.3: Devices Eligible for Transitional Pass-Through Payments
- 60.4: General Coding and Billing Instructions and Explanations
- 60.5: Services Eligible for New Technology APC Assignment and Payments
- 61: Billing for Devices under the OPPS
- 61.1: Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures
- 61.2: Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specified Devices are to be Reported With Procedure Codes
- 61.3: Billing for Devices Furnished Without Cost to an OPPS Hospital or Beneficiary or for Which the Hospital Receives a Full or Partial Credit and Payment for OPPS Services Required to Furnish the Device
- 61.3.1: Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital Prior to January 1, 2014
- 61.3.2: Reporting and Charging Requirements When the Hospital Receives Full Credit for the Replaced Device against the Cost of a More Expensive Replacement Device Prior to January 1, 2014
- 61.3.3: Reporting Requirements When the Hospital Receives Partial Credit for the Replaced Device Prior to January 1, 2014
- 61.3.4: Medicare Payment Adjustment Prior to January 1, 2014
- 61.4: Billing and Payment for Brachytherapy Sources
- 61.4.1: Billing for Brachytherapy Sources – General
- 61.4.2: Definition of Brachytherapy Source for Separate Payment
- 61.4.3: Billing of Brachytherapy Sources Ordered for a Specific Patient
- 61.4.4: Billing for Brachytherapy Source Supervision, Handling and Loading Costs
- 61.5: Billing for Intracoronary Stent Payment
- 90: Discontinuation of Value Code 05 Reporting
- 110: Procedures for Submitting Late Charges Under OPPS
- 120: General Rules for Reporting Outpatient Hospital Services
- 120.1: Bill Types Subject to OPPS
- 120.2: Routing of Claims
- 140: All-Inclusive Rate Hospitals
- 141: Maryland Waiver Hospitals
- 150: Hospitals That Do Not Provide Outpatient Services

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- 160: Clinic and Emergency Visits
- 160.1: Critical Care Services
- 170: Hospital and CMHC Reporting Requirements for Services Performed on the Same Day
- 180: Accurate Reporting of Surgical and Medical Procedures and Services
- 180.1: General Rules
- 180.2: Selecting and Reporting Procedure Codes
- 180.3: Unlisted Service or Procedure
- 180.4: Proper Reporting of Condition Code G0 (Zero)
- 180.5: Proper Reporting of Condition Codes 20 and 21
- 180.6: Emergency Room (ER) Services That Span Multiple Service Dates
- 180.7: Inpatient-only Services
- 200: Special Services for OPPS Billing
- 200.1: Billing for Corneal Tissue
- 200.2: Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)
- 200.3: Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS)
- 200.3.1: Billing for IMRT Planning and Delivery
- 200.3.2: Additional Billing Instructions for IMRT Planning
- 200.3.3: Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery
- 200.4: Billing for Amniotic Membrane
- 200.6: Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services
- 200.7: Billing for Cardiac Echocardiography Services
- 200.7.1: Cardiac Echocardiography Without Contrast
- 200.7.2: Cardiac Echocardiography With Contrast
- 200.8: Billing for Nuclear Medicine Procedures
- 200.9: Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients
- 200.10: Billing for Cost Based Payment for Certified Registered Nurse Anesthetists (CRNA) Services Furnished by Outpatient Prospective Payment System (OPPS) Hospitals
- 230: Billing and Payment for Drugs and Drug Administration
- 230.1: Coding and Payment for Drugs and Biologicals and Radiopharmaceuticals
- 230.2: Coding and Payment for Drug Administration
- 231: Billing and Payment for Blood, Blood Products, and Stem Cells and Related Services Under the Hospital Outpatient Prospective Payment System (OPPS)
- 231.1: When a Provider Paid Under the OPPS Does Not Purchase the Blood or Blood Products That It Procures from a Community Blood Bank, or When a Provider Paid Under the OPPS Does Not Assess a Charge for Blood or Blood Products Supplied by the Provider’s Own Blood Bank Other Than Blood Processing and Storage
- 231.2: When a Provider Paid Under the OPPS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPPS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage
- 231.3: Billing for Autologous Blood (Including Salvaged Blood) and Directed Donor Blood
- 231.4: Billing for Split Unit of Blood
- 231.5: Billing for Irradiation of Blood Products
- 231.6: Billing for Frozen and Thawed Blood and Blood Products
- 231.7: Billing for Unused Blood
- 231.8: Billing for Transfusion Services
- 231.9: Billing for Pheresis and Apheresis Services
- 231.10: Billing for Autologous Stem Cell Transplants
- 231.11: Billing for Allogeneic Stem Cell Transplants
- 231.12: Correct Coding Initiative (CCI) Edits
- 240: Inpatient Part B Hospital Services

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- 240.1: Editing of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
- 240.2: Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A
- 240.3: Implantable Prosthetic Devices
- 240.4: Indian Health Service/Tribal Hospital Inpatient Social Admits
- 240.5: Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services when Part A Payment Cannot Be Made
- 240.6: Submitting Provider-Liable "No-Pay" Part A Claims and Beneficiary Liability
- 250.17: Payment of Global Surgical Split Care in a Method II CAH Submitted with Modifier 54 and/or 55
- 270: Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW)
- 290: Outpatient Observation Services
- 290.1: Observation Services Overview
- 290.2: General Billing Requirements for Observation Services
- 290.2.1: Revenue Code Reporting
- 290.2.2: Reporting Hours of Observation
- 290.4: Billing and Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007
- 290.4.1: Billing and Payment for All Hospital Observation Services Furnished Between January 1, 2006 and December 31, 2007
- 290.4.2: Separate and Packaged Payment for Direct Referral for Observation Services Furnished Between January 1, 2006 and December 31, 2007
- 290.4.3: Separate and Packaged Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007
- 290.5: Billing and Payment for Observation Services Furnished on or After January 1, 2008
- 290.5.1: Billing and Payment for Observation Services Beginning January 1, 2008
- 290.5.2: Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008
- 290.6: Services Not Covered as Observation Services

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IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf
Chapter 5, "Part B Outpatient Rehabilitation and CORF/OPT Services," includes the following sections about outpatient therapy billing:

- 20.1: Discipline Specific Outpatient Rehabilitation Modifiers – All Claims
- 20.2: Reporting of Service Units With HCPCS
- 20.3: Determining What Time Counts Towards 15-Minute Timed Codes – All Claims
- 20.4: Coding Guidance for Certain CPT Codes – All Claims
- 40: Special Claims Processing Rules for Institutional Outpatient Rehabilitation Claims
- 40.2: Applicable Types of Bill
- 40.3: Applicable Revenue Codes
- 40.4: Edit Requirements for Revenue Codes
- 40.5: Line Item Date of Service Reporting
- 40.6: Non-covered Charge Reporting
- 40.7: Billing for Biofeedback Training for the Treatment of Urinary Incontinence
- 50: CWF and PS&R Requirements – A/B MAC (A)

Webpage – Therapy Services

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html
This page provides helpful information on outpatient therapy payment caps, billing scenarios, and therapy updates.

MLN Matters® Article – MM8005 Revised "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services – Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf
This MLN Matters® article explains the implementation of a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new non-payable functional G-codes and seven new modifiers on claims for Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services.

MLN Matters® Article – MM8048 "Enforcing Interim Billing for Partial Hospitalization Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8048.pdf
This MLN Matters® article explains that Medicare systems enforce consistency editing for interim claims billing for Partial Hospital Program services, which may impact the processing of claims for these services.

Inpatient Part A and Outpatient/Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
Search for hospital in Chapter 13, "Radiology Services and Other Diagnostic Procedures."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Search for hospital in Chapter 17, "Drugs and Biologicals."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," has information for both Part A and Part B billing by hospitals.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 32

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Chapter 32, "Billing Requirements for Special Services," includes billing requirements for services such as: Hyperbaric Oxygen (HBO) therapy, bariatric surgery for morbid obesity, and qualifying clinical trials, as well as many other topics of possible interest to hospitals that resulted from an NCD or change in coverage in the law.

CLAIMS PROCESSING AND PAYMENT

Webpage – EHR Incentive Programs

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms
This webpage explains how the Medicare EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Webpage – ICD-10 – ICD-10 MS-DRG Conversion Project

https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html

This webpage provides information on the project for using the General Equivalence Mappings (GEMs) to convert the MS-DRGs ICD-10-CM.

Webpage – Medicare Geographic Classification Review Board (MGCRB)

https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html
From this webpage, a hospital can access instructions and applications for reclassification to another area (urban or in some cases rural) for the purposes of receiving a higher wage index. The MGCRB's decisions on reclassification requests must be rendered within a statutorily mandated 180 day time frame that begins on September 1st of each year.

Webpage – Section 1011 – Emergency Health Services Furnished to Undocumented Aliens – Service Furnished to Undocumented Aliens

https://www.cms.gov/Regulations-and-Guidance/Legislation/UndocAliens/index.html
This webpage provides an overview of Section 1011, discussing payment for undocumented aliens.

Fact Sheet – "Hospital Reclassifications"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1252330.html
This fact sheet is designed to provide education on hospital reclassifications. It includes the following information: urban to rural reclassification, geographic reclassification, Rural Referral Center status, Sole Community Hospital status, and Critical Access Hospital status.

Fact Sheet – "Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Section_1011_Fact_Sheet.pdf
Learn about: available funding; eligibility and program enrollment for undocumented aliens; and states that have exhausted payment and reimbursable services.

Form – CMS-10130B "Request For Section 1011 Hospital On-Call Payments To Physicians"

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10130B.pdf
Section 1011 (c)(3)(C)(ii) of MMA 2003 provides for the election by a hospital for a portion of the on-call payments made by the hospital to physicians. If a hospital made the election under section 1011(c)(3)(C)(ii), complete the entire form.

Acute Inpatient Hospital

IOM – "Medicare Policy Benefit Manual," Pub. 100-02, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf
Chapter 5, "Lifetime Reserve Days," includes information on the effect of using lifetime reserve days on IPPS payment.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," provides claims processing and payment information for inpatient hospitals:

- 10: General Inpatient Requirements
- 10.1: Claim Formats
- 10.2: Focused Medical Review (FMR)
- 10.3: Spell of Illness

- 10.4: Payment of Nonphysician Services for Inpatients
- 10.5: Hospital Inpatient Bundling
- 20: Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
- 20.1: Hospital Operating Payments Under PPS
- 20.1.1: Hospital Wage Index
- 20.1.2: Outliers
- 20.1.2.1: Cost to Charge Ratios
- 20.1.2.2: Statewide Average Cost to Charge Ratios
- 20.1.2.3: Threshold and Marginal Cost
- 20.1.2.4: Transfers
- 20.1.2.5: Reconciliation
- 20.1.2.6: Time Value of Money
- 20.1.2.7: Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
- 20.1.2.8: Special Outlier Payments for Burn Cases
- 20.1.2.9: Medical Review and Adjustments
- 20.1.2.10: Return Codes for Pricer
- 20.2: Computer Programs Used to Support Prospective Payment System
- 20.2.1: Medicare Code Editor (MCE)
- 20.2.1.1: Paying Claims Outside of the MCE
- 20.2.1.1.1: Requesting to Pay Claims Without MCE Approval
- 20.2.1.1.2: Procedures for Paying Claims Without Passing through the MCE
- 20.2.2: DRG GROUPER Program
- 20.2.3: PPS Pricer Program
- 20.3: Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients
- 20.3.1: Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation
- 20.3.1.1: Clarification for Cost Reporting Periods Beginning On or After January 1, 2000
- 20.3.1.2: Hold Harmless for Cost Reporting Periods Beginning Before January 1, 2000
- 20.3.1.3: Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009
- 20.3.1.4: Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2012
- 20.3.2: Updates to the Federal Fiscal Year (FY) 2001
- 20.3.2.1: Inpatient Hospital Payments and Disproportionate Share Hospital (DSH) Thresholds and Adjustments
- 20.3.3: Prospective Payment Changes for Fiscal Year (FY) 2003
- 20.3.4: Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond
- 20.4: Hospital Capital Payments Under PPS
- 20.4.1: Federal Rate
- 20.4.2: Hold Harmless Payments
- 20.4.3: Blended Payments
- 20.4.4: Capital Payments in Puerto Rico
- 20.4.5: Old and New Capital
- 20.4.6: New Hospitals
- 20.4.7: Capital PPS Exception Payments
- 20.4.8: Capital Outliers
- 20.4.9: Admission Prior to and Discharge After Capital PPS Implementation Date
- 20.4.10: Market Basket Update
- 20.5: Rural Referral Centers (RRCs)
- 20.6: Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals
- 20.7: Billing Applicable to PPS
- 20.7.1: Stays Prior to and Discharge After IPPS Implementation Date
- 20.7.2: Split Bills

- 20.7.3: Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
- 20.7.4: Cost Outlier Bills With Benefits Exhausted
- 20.8: Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare Advantage (MA) Enrollees
- 30: Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)
- 30.1: Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units
- 30.1.1: Payment for Inpatient Services Furnished by a CAH
- 30.1.1.1: Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH
- 30.1.2: Payment for Post-Hospital SNF Care Furnished by a CAH
- 30.1.3: Costs of Emergency Room On-Call Providers
- 30.1.4: Costs of Ambulance Services
- 40: Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals
- 40.1: “Day Count” Rules for All Providers
- 40.2: Determining Covered/Noncovered Days and Charges
- 40.2.1: Noncovered Admission Followed by Covered Level of Care
- 40.2.2: Charges to Beneficiaries for Part A Services
- 40.2.3: Determining Covered and Noncovered Charges – Pricer and PS&R
- 40.2.4: IPPS Transfers Between Hospitals
- 40.2.5: Repeat Admissions
- 40.2.6: Leave of Absence
- 40.3: Outpatient Services Treated as Inpatient Services
- 40.3.1: Billing Procedures to Avoid Duplicate Payments
- 50: Adjustment Bills
- 50.1: Tolerance Guidelines for Submitting Adjustment Requests
- 50.2: Claim Change Reasons
- 50.3: Late Charges
- 60: Swing-Bed Services
- 70: All-Inclusive Rate Providers
- 70.1: Providers Using All-Inclusive Rates for Inpatient Part A Charges
- 80: Hospitals That Do Not Charge
- 80.1: Medicare Summary Notice (MSN) for Services in Hospitals That Do Not Charge
- 90: Billing Transplant Services
- 90.1: Kidney Transplant – General
- 90.1.1: The Standard Kidney Acquisition Charge
- 90.1.2: Billing for Kidney Transplant and Acquisition Services
- 90.1.3: Billing for Donor Post-Kidney Transplant Complication Services
- 90.2: Heart Transplants
- 90.3: Stem Cell Transplantation
- 90.3.1: Allogeneic Stem Cell Transplantation
- 90.3.2: Autologous Stem Cell Transplantation (AuSCT)
- 90.3.3: Billing for Stem Cell Transplantation
- 90.4: Liver Transplants
- 90.4.1: Standard Liver Acquisition Charge
- 90.4.2: Billing for Liver Transplant and Acquisition Services
- 90.5: Pancreas Transplants With Kidney Transplants
- 90.5.1: Pancreas Transplants Alone (PA)
- 90.6: Intestinal and Multi-Visceral Transplants
- 100: Billing Instructions for Specific Situations
- 100.1: Billing for Abortion Services

- 100.2: Payment for CRNA or AA Services
- 100.3: Resident and Interns Not Under Approved Teaching Programs
- 100.4: Billing for Services After Termination of Provider Agreement
- 100.4.1: Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number
- 100.5: Review of Hospital Admissions of Patients Who Have Elected Hospice Care
- 100.6: Inpatient Renal Services
- 100.7: Lung Volume Reduction Surgery
- 100.8: Replaced Devices Offered Without Cost or With a Credit

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following sections:

- 6.5: Medical Review of Inpatient Hospital Claims
- 6.5.1: Screening Instruments
- 6.5.2: Medical Review of Inpatient Prospective Payment System (IPPS) Hospital and Long Term Care Hospital (LTCH) Claims
- 6.5.3: DRG Validation Review
- 6.5.4: Review of Procedures Affecting the DRG
- 6.5.5: Special Review Considerations
- 6.5.6: Length-of-Stay Review
- 6.5.9: Circumvention of PPS

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Part 1 of "The Provider Reimbursement Manual" includes important payment information for inpatient hospital services. Edit/Search for hospital in chapters of interest. Examples include interim payments for items paid on a reasonable cost basis, Periodic Interim Payments (PIP), overpayments, and accelerated payments.

Paper-Based Manual – "The Provider Reimbursement Manual-Part 2," Pub. 15-2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Part 2 of "The Provider Reimbursement Manual" includes important payment information about hospital cost reporting. Edit/Search for hospital in chapters of interest.

Webpage – Acute Inpatient Prospective Payment System (IPPS)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
This webpage provides information on payments for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates.

Webpage – PC Pricer – Inpatient PPS PC Pricer

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html
This webpage provides Pricer information for IPPS hospitals. The PC Pricer is a tool used to estimate Medicare PPS payments.

Webpage – Transmittals

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Use this webpage to search for Transmittals issued for Acute Inpatient PPS providers and topics. On the left side of the page select the year you would like to search, then in the search box enter the topic IPPS.

Webpage – Acute Inpatient PPS – IPPS Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/IPPS-Regulations-and-Notices.html
Use this webpage to search for Transmittals issued for Acute Inpatient PPS providers and topics. On the left side of the page select the year you would like to research, then in the search box enter the topic you are searching for.

Booklet – "Acute Care Hospital Inpatient Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243657.html
Learn about: Acute Care Hospital Inpatient Prospective Payment System (IPPS) background; basis for IPPS payment, payment rates, how payment rates are set, and payment updates; and Hospital Inpatient Quality Reporting Program.

Web-Based Training – "Acute Care and the IPPS"

https://learner.mlnlms.com/
Learn about coverage and payment under the IPPS; inpatient hospital coverage, billing, and payment; for beneficiaries enrolled in Original Medicare.

MLN Matters® Article – MM7142 Revised "Clarification of Payment Window for Outpatient Services Treated as Inpatient Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7142.pdf
This MLN Matters® article describes Section 102 of the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's inpatient admission or during the 3 calendar days immediately preceding the date of a beneficiary's inpatient admission to a subsection (d) hospital subject to the inpatient prospective payment system (or during the 1 calendar day preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital).

MLN Matters® Article – SE1232 "Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1232.pdf
This Special Edition MLN Matters® article provides answers to frequently asked questions regarding the 3-day payment window for services provided to outpatients of a hospital who later are admitted as inpatients.

MLN Matters® Article – MM9195 Revised "The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2013 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9195.pdf
This MLN Matters® article provides updated data for determining the disproportionate share adjustment for IPPS hospitals and the low income patient adjustment for IRFs. The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, CMS certification number, SSI days, total Medicare days, and the ratio of Medicare Part A beneficiary days attributable to SSI recipients.

MLN Matters® Article – MM8067 "Affordable Care Act Section 3025 Expansion of a Field in the Inpatient Provider Specific File (PSF)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8067.pdf
This MLN Matters® article explains that under section 3025 of the Affordable Care Act, certain hospitals will receive a readmission adjustment factor that is the higher of a ratio described or a floor specified in section 1886(q)(3) of the Act.

Critical Access Hospital

More Resources: Refer to the Critical Access Hospital (CAH) pathway for additional information.

IPPS Excluded Cancer Hospital

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 30, "NON-PPS Hospitals and Distinct Part Units," includes Section 3001.9, "Cancer Hospitals."

Webpage – Acute Inpatient PPS – Medicare PPS Excluded Cancer Hospitals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html
This webpage lists the cancer hospitals excluded from IPPS.

Children's Hospital

Webpage – Social Security Act – Payment to Hospitals for Inpatient Hospital Services, Section 1886

https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
Section 1886(d)(1)(B)(iii) defines a children's hospital as a hospital whose inpatients are predominantly individuals under 18 years of age.

Medicare Dependent Hospital

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 20.6, "Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals."

Medicare Disproportionate Share Hospital

Fact Sheet – "Medicare Disproportionate Share Hospital"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243366.html
This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH). It includes the following information: background; methods to qualify for the Medicare DSH adjustment; Affordable Care Act provision that impacts Medicare DSHs; Medicare Prescription Drug, Improvement, and Modernization Act provisions

that impact Medicare DSHs; number of beds in hospital determination; Medicare DSH payment adjustment formulas; resources; and lists of helpful websites and Regional Office Rural Health Coordinators.

Rural Referral Center

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 20.5, "Rural Referral Centers (RRCs)."

Fact Sheet – "Rural Referral Center Program"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243365.html
This fact sheet is designed to provide education on the Rural Referral Center (RRC) Program. It includes the following information: background, RRC Program requirements, urban to rural reclassification, and RRC status.

Sole Community Hospital

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 20.6, "Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals."

Fact Sheet – "Acute Care Hospital Inpatient Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243657.html
Learn about: Acute Care Hospital Inpatient Prospective Payment System (IPPS) background; basis for IPPS payment, payment rates, how payment rates are set, and payment updates; and Hospital Inpatient Quality Reporting Program.

Specialty Hospitals

Webpage – Physician Self Referral – Specialty Hospital Issues

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/specialty_hospital_issues.html
This webpage provides information regarding physician referrals to specialty hospitals in which they have an ownership or investment interest.

Document – "Recommendations on Physician-Owned Specialty Hospitals"

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/RTCPhysSpecHospPt2.pdf
This document outlines the recommendations made to Congress for administrative or statutory changes relative to specialty hospitals.

Study – "Study of Physician-Owned Specialty Hospitals"

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/RTCPhysSpecHosp.pdf
This document summarizes the study of physician-owned cardiac, surgery, and orthopedic specialty hospitals required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Swing Bed Hospital

More Resources: Once the beneficiary starts to receive a SNF level of care in a swing bed hospital, refer to the SNF pathway for additional information on coverage, billing, and payment of services to Medicare beneficiaries.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 60, "Swing-Bed Services."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
Chapter 6, "SNF Inpatient Part A Billing and SNF Consolidated Billing," includes the following sections related to swing bed hospitals:

- 100: Part A SNF PPS for Hospital Swing Bed Facilities
- 100.1: Swing Bed Services Not Included in the Part A PPS Rate

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following sections related to swing bed hospitals:

- 2018: Reinstatement Following Termination of Swing-Bed – Approval
- 2036: Definition, Authority and Requirements for Hospital Providers of Extended Care Services ("Swing-Beds")
- 2037A: Request from a Medicare Participating Hospital to Add Swing-Bed Approval
- 2037B: Screening
- 2037C: Provider Agreement
- 2037D: Calculation of Bed Count
- 2037E: Rural Area
- 2037F: Certificate Of Need (CON) Approval
- 2038: Survey Procedures for Swing-Bed Approval
- 2039: Post-Survey Procedures for Swing-Bed Hospitals
- 2040: RO Approval Procedures for Swing-Bed Approval
- 2259: Procedures for Processing CAH Swing-Bed Applications
- 2259A: Definition, Authority and Requirements for CAH Providers of Extended Care Services ("Swing-Beds")
- 2259B: Request from a Medicare Participating CAH to add Swing-bed Approval
- 2259C: Pre-Survey Activity
- 2259D: Certificate Of Need (CON) Approval
- 2260: Survey Procedures for Swing-Bed Approval
- 2261: Post-Survey Procedures for Swing-Bed CAHS
- 2262: RO Approval Procedures for Swing-Bed Approval
- 2779C: Special Numbering System for Units of Hospitals That Are Excluded From Prospective Payment System (PPS) and Hospitals With SNF Swing-Bed Designation

IOM – "State Operations Manual," Pub. 100-07, Appendix T

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_t_swing_beds.pdf
Appendix T, "Regulations and Interpretive Guidelines for Swing Beds in Hospitals," includes information about the requirements for swing bed hospitals.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.8, "Hospitals and Hospital Units," which provides information on swing-bed designations.

IOM – "Quality Improvement Organization Manual," Pub. 100-10, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf
Chapter 4, "Case Review," includes swing bed information about liability determinations, Hospital-Issued Notices of Non-coverage (HINN) information, and other financial liability information pertinent to a quality review.

IOM – "Quality Improvement Organization Manual," Pub. 100-10, Chapter 7

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c07.pdf
Chapter 7, "Denials, Reconsiderations, Appeals," includes swing bed information about liability determinations, HINN information, and other financial liability information.

More Resources: Refer to the Medicare Learning Network® booklet titled "Medicare Billing Information for Rural Providers and Suppliers" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html for more information regarding billing for rural services.

Webpage – Skilled Nursing Facility PPS – Swing Bed Providers

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html
This webpage provides links to information for swing bed providers including links to the Minimum Data Set (MDS) Form, data specifications for the MDS for swing bed hospitals, a swing bed manual, and a list of changes to the swing bed manual.

Webpage – Nursing Home Quality Initiaitve – MDS 3.0 for Nursing Homes and Swing Bed Providers

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
The MDS is a powerful tool for implementing standardized assessment and for facilitating care management in Nursing Homes (NHs) and non-critical access hospital Swing Beds (SBs). This webpage includes MDS information for swing bed hospitals.

Webpage – Minimum Data Sets 2.0 Tool and Public Reports – RAVEN_SB (Software for Swing Bed)

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MinimumDataSets20/RAVEN_SBSoftwareForSwingBed.html
RAVEN-SB is a computerized data entry system for swing bed facilities that offers users the ability to collect SB-MDS assessments in a database and transmit those assessments in CMS' standard format to the National Assessment Collection Database. This webpage includes downloads for the RAVEN-SB software as well as installation instructions and a user's manual.

Fact Sheet – "Swing Bed Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html
Learn about swing bed services background, requirements that apply to hospitals and Critical Access Hospitals, and payments.

Document – "SNF PPS Swing Bed Data Specifications"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/downloads/SB_dataspecs.pdf
Version 5.20S of the Resource Utilization Group (RUG)-III Grouper for Swing Beds supports both the original 44-group RUG-III model and a new 53-group RUG-III model. The new 53-group model is required for swing bed PPS days of service beginning January 1, 2006. This document provides data specifications for Version 5.20S.

Teaching Hospital

Webpage – Acute Inpatient PPS – Indirect Medical Education (IME)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME.html
This webpage explains that prospective payment hospitals that have residents in an approved Graduate Medical Education (GME) program receive an additional payment for a Medicare discharge to reflect the higher beneficiary care costs of teaching hospitals relative to non-teaching hospital.

Outpatient/Part B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," includes information about Part B payment:

- 10: Hospital Outpatient Prospective Payment System (OPPS)
- 10.1: Background
- 10.1.1: Payment Status Indicators
- 10.2: APC Payment Groups
- 10.2.1: Composite APCs
- 10.2.3: Comprehensive APCs
- 10.3: Calculation of APC Payment Rates
- 10.4: Packaging
- 10.4.1: Combinations of Packaged Services of Different Types That are Furnished on the Same Date of Service
- 10.5: Discounting
- 10.6: Payment Adjustments
- 10.6.1: Payment Adjustment for Certain Rural Hospitals
- 10.6.2: Payment Adjustment for Failure to Meet the Hospital Outpatient Quality Reporting Requirements
- 10.6.2.1: Hospitals to Which the Payment Reduction Applies
- 10.6.2.2: Services to which the Payment Reduction Applies
- 10.6.2.3: Contractor Responsibilities
- 10.6.2.4: Application of the Payment Reduction Factor in Calculation of the Reduced Payment and Reduced Copayment
- 10.6.3: Payment Adjustment for Certain Cancer Hospitals
- 10.6.3.1: Payment Adjustment for Certain Cancer Hospitals for CY 2012 and CY 2013
- 10.7: Outliers
- 10.7.1: Outlier Adjustments
- 10.7.2: Outlier Reconciliation
- 10.7.2.1: Identifying Hospitals and CMHCs Subject to Outlier Reconciliation
- 10.7.2.2: Reconciling Outlier Payments for Hospitals and CMHCs
- 10.7.2.3: Time Value of Money
- 10.7.2.4: Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
- 10.8: Geographic Adjustments
- 10.8.1: Wage Index Changes
- 10.9: Updates

- 10.10: Biweekly Interim Payments for Certain Hospital Outpatient Items and Services That Are Paid on a Cost Basis, and Direct Medical Education Payments, Not Included in the Hospital Outpatient Prospective Payment System (OPPS)
- 10.11: Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS
- 10.11.1: Requirement to Calculate CCRs for Hospitals Paid Under OPPS and for CMHCs
- 10.11.2: Circumstances in Which CCRs are Used
- 10.11.3: Selection of the CCR to be Used
- 10.11.3.1: CMS Specification of Alternative CCR
- 10.11.3.2: Hospital or CMHC Request for Use of a Different CCR
- 10.11.3.3: Notification to Hospitals Paid Under the OPPS of a Change in the CCR
- 10.11.4: Use of CCRs in Mergers, Acquisitions, Other Ownership Changes, or Errors Related to CCRs
- 10.11.5: New Providers and Providers with Cost Report Periods Less Than a Full Year
- 10.11.6: Substitution of Statewide CCRs for Extreme OPPS Hospital Specific CCRs
- 10.11.7: Methodology for Calculation of Hospital Overall CCR for Hospitals that Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010 Under Cost Report Form 2552-96
- 10.11.7.1: Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10
- 10.11.8: Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96
- 10.11.8.1: Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10
- 10.11.9: Methodology for Calculation of CCR for CMHCs
- 10.11.10: Location of Statewide CCRs, Tolerances for Use of Statewide CCRs in Lieu of Calculated CCRs and Cost Centers to be Used in the Calculation of CCRs
- 10.11.11: Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs
- 10.12: Payment Window for Outpatient Services Treated as Inpatient Services
- 30.2: Calculating the Medicare Payment Amount and Coinsurance
- 40: Outpatient Code Editor (OCEs)
- 40.1: Integrated OCE (July 2007 and Later)
- 40.1.1: Patient Status Code and Reason for Patient Visit for the Hospital OPPS
- 40.2: Outpatient Prospective Payment System (OPPS) OCE (Prior to July 1, 2007)
- 40.2.1: Patient Status Code and Reason for Patient Visit for the Hospital OPPS
- 40.3: Non-OPPS OCE (Rejected Items and Processing Requirements) Prior to July 1, 2007
- 40.4: Paying Claims Outside of the IOCE
- 40.4.1: Requesting to Pay Claims Without IOCE Approval
- 40.4.2: Procedures for Paying claims Without Passing through the IOCE
- 50: Outpatient PRICER
- 50.2: Deductible Application
- 50.3: Transitional Pass-Throughs for Designated Drugs or Biologicals
- 50.4: Transitional Pass-Throughs for Designated Devices
- 50.5: Changes to Pricer Logic Effective April 1, 2002
- 50.6: Changes to the OPPS Pricer Logic Effective January 1, 2003
- 50.7: Changes to the OPPS Pricer Logic, Effective January 1, 2003 Through January 1, 2006
- 50.8: Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later
- 70: Transitional Corridor Payments
- 70.1: TOPs Calculation for CY 2000 and CY 2001
- 70.2: TOPs Calculation for CY 2002

- 70.3: TOPs Calculation for CY 2003
- 70.4: TOPs Calculation for CY 2004 and CY 2005
- 70.5: TOPs Calculation for CY 2006 - CY 2008
- 70.6: Transitional Outpatient Payments (TOPs) for CY 2009
- 70.7: Transitional Outpatient Payments (TOPs) for CY 2010 through CY 2012
- 70.8: TOPs Overpayments
- 80.1: Background – Payment-to-Cost Ratios
- 80.2: Using the Newly Calculated PCR for Determining Final TOP Amounts
- 80.3: Using the Newly Calculated PCR for Determining Interim TOPs

Webpage – Hospital Outpatient Prospective Payment System (OPPS)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html
This webpage discusses the authority for CMS to implement OPPS under Medicare for hospital outpatient services and certain Part B services furnished to hospital inpatients for beneficiaries who have no Part A coverage.

Webpage – Transmittals

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Use this webpage to search for Transmittals issued for OPPS providers and topics. On the left side of the page select the year you would like to research, then in the search box enter the topic you are searching for.

Webpage – Hospital Outpatient PPS – Hospital Outpatient Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
This webpage shows the Federal regulations and notices for the Hospital Outpatient Prospective Payment System.

Webpage – National Correct Coding Initiative Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
This webpage explains that a subset of National Correct Coding Initiative (NCCI) edits is incorporated into the OCE for OPPS providers.

Webpage – Outpatient Code Editor (OCE)

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html
This webpage includes links to information about the OCE, which assigns Ambulatory Payment Classifications (APCs) and edits claims.

Webpage – National Correct Coding Initiative Edits – Medically Unlikely Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
CMS developed MUEs to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/Current Procedural Terminology (CPT) code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Scroll to the bottom of this webpage and click on Facility Outpatient Services MUE Table.

Webpage – Therapy Services – Annual Therapy Update

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html
The files on this webpage contain the list of codes indicating whether they are sometimes or always therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

Fact Sheet – "Hospital Outpatient Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243664.html
Learn about: background; ambulatory payment classifications; how payment rates are set and payment rates; and Hospital Outpatient Quality Reporting Program.

MLN Matters® Article – MM7050 Revised "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf
This MLN Matters® article provides information on the MPPR to the Practice Expense (PE) component of payment of select therapy services paid under the MPFS. Many therapy services are time-based codes, for example, multiple units may be billed for a single procedure. CMS is applying an MPPR to the practice expense payment when more than one unit or procedure is provided to the same beneficiary on the same day, for example, the MPPR applies to multiple units as well as multiple procedures.

MLN Matters® Article – SE1134 Revised "Medicare Payments for Diagnostic Radiology Services in Emergency Departments"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1134.pdf
This Special Edition MLN Matters® article highlights a report from the Office of Inspector General (OIG) entitled "Medicare Payments for Diagnostic Radiology Services in Emergency Departments" along with the Medicare policy regarding the coverage of radiology services.

MLN Matters® Article – MM7703 "Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7703.pdf
This MLN Matters® article announces CMS has discontinued the use of the global cap amount in calculating global payments of certain diagnostic imaging procedures. The article is a reminder the MPPR will also be applied to the Professional Component (PC) of such services.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following information about hospital beneficiary notices:

- 60.1.1: Basic Payment Liability Conditions
- 150.2: Hospital Claims Subject to Hospital Issued Notices of Noncoverage
- 150.2.1: Scope of Issuance of Hospital Issued Notices of Noncoverage (HINNs)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes the following sections about hospital beneficiary notices:

- 50: Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)
- 50.1: Introduction – General Information

- 50.2: General Statutory Authority – Financial Liability Protections Provisions (FLP) of Title XVIII
- 50.3: ABN Scope
- 50.3.1: Mandatory ABN Uses
- 50.3.2: Voluntary ABN Uses
- 50.4: Issuance of the ABN
- 50.4.1: Issuers of ABNs (Notifiers)
- 50.4.2: Recipients of the ABN
- 50.4.3: Representatives of Beneficiaries
- 50.5: ABN Triggering Events
- 50.6: ABN Standards
- 50.6.1: Proper Notice Documents
- 50.6.2: General Notice Preparation Requirements
- 50.6.3: Completing the ABN
- 50.6.4: Retention Requirements
- 50.6.5: Other Considerations During ABN Completion
- 50.7: ABN Delivery Requirements
- 50.7.1: Effective Delivery
- 50.7.2: Options for Delivery Other than In Person
- 50.7.3: Effects of Lack of Notification, Medicare Review and Claim Adjudication
- 80: Hospital ABNs (Hospital-Issued Notices of Noncoverage – HINN)
- 130.3: Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds
- 130.4: Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed
- 200: Expedited Review Process for Hospital Inpatients in Original Medicare
- 200.1: Scope of the Instructions
- 200.2: Special Considerations
- 200.3: Notifying Beneficiaries of their Right to an Expedited Review
- 200.3.1: Delivery of the Important Message from Medicare
- 200.3.2: The Follow-Up Copy of the signed Important Message from Medicare
- 220: Hospital Requested Expedited Review
- 220.1: Responsibilities of the Hospital
- 220.2: Responsibilities of the QIO
- 220.3: Effect of the Hospital Requested Expedited Determination
- 220.4: General Notice Requirements
- 220.5: Exhibit 3 – Model Language for Notice of Hospital Requested Review
- 240: Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN)
- 240.1: Delivery of the Preadmission/Admission HINN
- 240.2: Notice Delivery Timeframes and Liability
- 240.3: Timeframes for Submitting a Request for a QIO Review
- 240.4: Results of the QIO Review
- 240.5: Effect of the QIO Review
- 240.6: Exhibit 4 – Model Language Preadmission/Admission Hospital Issued Notice of Noncoverage
- 260: Expedited Determinations of Provider Service Terminations
- 300: Expedited Reconsiderations
- 300.1: The Role of the Beneficiary and Liability
- 300.2: The Responsibilities of the IRE
- 300.3: The Responsibilities of the QIO
- 300.4: The Responsibilities of the Provider
- 300.5: Coverage During an Expedited Reconsideration

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)," has information of interest to hospitals regarding beneficiary notices.

Webpage – Beneficiary Notices Initiative (BNI) – FFS ABN

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. Notifiers include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and RNHCIs paid exclusively under Part A.

Webpage – Beneficiary Notices Initiative (BNI) – Hospital Discharge Appeal Notices

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html
This webpage discusses informing beneficiaries who are hospital inpatients about their hospital discharge appeal rights.

QUALITY

IOM – "Quality Improvement Organization Manual," Pub. 100-10, Chapter 11

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c11.pdf
Chapter 11, "Hospital Payment Monitoring Program (HPMP)," explains HPMP and a hospital's responsibilities under the program.

IOM – "Quality Improvement Organization Manual," Pub. 100-10, Chapter 14

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c14.pdf
Chapter 14, "Hospital-Generated Data Reporting," explains a hospital's responsibility to report data electronically in support of the Health Care Quality Improvement Program (HCQIP).

IOM – "Medicare Managed Care Manual," Pub. 100-16, Chapter 13

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf
Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)," explains that QIOs review complaints raised by enrollees about the quality of care provided by hospitals.

IOM – "Demonstrations," Pub. 100-19

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_19.pdf
This "Demonstration Manual" includes information from Transmittal R86DEMO which discusses the implementation of the hospital value-based purchasing program and hospital readmission reduction program for the rural community hospital demonstration.

Webpage – Hospital Quality Initiative

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html
The Hospital Quality Initiative (HQI), like other CMS quality initiatives, consists of many facets. Its goals are to improve

the care provided by the nation's hospitals and to provide quality information to consumers and others. CMS has several efforts in progress to provide hospital quality information to consumers and others and improve the care provided by the nation's hospitals. This page provides information on hospital quality initiatives including hospital inpatient value-based purchasing.

Website – QualityNet

https://www.qualitynet.org
Established by CMS, QualityNet provides health care quality improvement news, resources and data reporting tools and applications used by health care providers and others. QualityNet is the only CMS-approved website for secure communications and health care quality data exchange between: QIOs, hospitals, physician offices, nursing homes, ESRD networks and facilities, and data vendors. Click on Hospitals-Inpatient or Hospitals-Outpatient in the banner.

Webpage – Hospital Compare – Find a Hospital

https://www.medicare.gov/hospitalcompare/search.html
The Hospital Compare webpage provides hospital contact information, compares information about the quality of care and services these providers offer, and provides helpful tips on what to look for when comparing and choosing a provider.

Fact Sheet – "Hospital Value-Based Purchasing Program"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1255514.html
Learn about: how the VBP Program Measures Hospital Performance, Hospital VBP Program Measures, and how the Hospital VBP Program is Funded.

MLN Matters® Article – SE1114 Revised "New Information To Improve Patient Safety At America's Hospitals"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1114.pdf
This Special Edition MLN Matters® article alerts providers that they may review and share data about HACs with their Medicare beneficiaries.

Outpatient/Part B

Webpage – Hospital Quality Initiative – Highlights

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHighlights.html
Important new information about the quality of care available in America's outpatient and emergency departments, including how well hospitals care for beneficiaries with heart attacks and protect outpatients from surgical infections was added to the new Department of Health and Human Services (HHS) website HealthCare.gov. The information can be found as part of the Compare Care Quality link on the front page of the new site. It can also be found on the CMS Hospital Compare website.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Open Door Forums Hospitals – Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_Hospitals.html
The Hospital Open Door Forum (ODF) addresses concerns and questions of the hospital service setting. The very broad scope of topics discussed within this forum includes payment, coverage, conditions of participation, billing, and many other current issues that are related to new policy implementation. The Inpatient PPS, Outpatient PPS, and the many MMA provisions that affect the setting are all covered, and a recurring update from the areas of the Hospital Quality Initiative including the hospital Consumer Assessment of Health Providers and Systems (CAHPS) initiative. Timely announcements and clarifications regarding important rulemaking, agency program initiatives, and other related areas are also included in the forums.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQ) webpage allows providers to ask questions related to Medicare. Search under the term hospital for related questions and answers. For example, FAQ3235 addresses hospitals, nursing homes, home health, SNF, and hospice as part of the continuum of care.

Website – Office of Inspector General, U. S. Department of Health and Human Services

https://oig.hhs.gov
The OIG has issued reports about hospitals. Use the search feature on the home page of this website to review these.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Beneficiary Fact Sheet – "Are You a Hospital Inpatient or Outpatient?"

https://www.medicare.gov/Pubs/pdf/11435.pdf
This fact sheet explains how hospital status affects how much a person pays for hospital services and whether their stay in a skilled nursing facility will be covered.

Beneficiary Brochure – "Medicare & Your Hospital Benefits"

https://www.medicare.gov/Pubs/pdf/11408-Medicare-Hospital-Benefits-Getting-Start.pdf
This brochure provides an overview of how Medicare covers inpatient and outpatient hospital services.

Inpatient/Part A

Electronic Mailing List – Acute Hospitals

https://list.nih.gov/cgi-bin/wa.exe?A0=HOSPITALS-ACUTE-L
The Acute Hospital electronic mailing list is administered by CMS, which emails subscribers information regarding acute hospital policy, publications, coding, payment, and educational material.

Outpatient/Part B

Beneficiary Booklet – "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings"

https://www.medicare.gov/Pubs/pdf/11333.pdf
This booklet provides information about how to get reimbursed through Medicare Part D for self-administered drugs you get in hospital outpatient settings.

Beneficiary Fact Sheet – "Quick Facts About Payment for Outpatient Services for People with Medicare Part B"

https://www.medicare.gov/Pubs/pdf/02118.pdf
This fact sheet has information about how outpatient services are paid for people with Medicare Part B.

Electronic Mailing List – OP-PPS – Hospital Outpatient Departments

https://list.nih.gov/cgi-bin/wa.exe?A0=OP-PPS-L
The Outpatient PPS electronic mailing list is administered by CMS, which emails subscribers information regarding OPPS policy, publications, coding, payment, and educational material.

CRITICAL ACCESS HOSPITAL

INTRODUCTION

This curriculum is designed as a pathway to Critical Access Hospital Medicare resources.

DEFINITION: CRITICAL ACCESS HOSPITAL (CAH)

Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by the Centers for Medicare & Medicaid Services (CMS). A facility that meets the following criteria may be designated by CMS as a CAH:

- Is located in a State that has established with CMS a Medicare rural hospital Flexibility Program
- Has been designated by the State as a CAH
- Is currently participating in Medicare as a hospital or was a participating hospital that ceased operation after November 29, 1989 or is a health clinic or health center that was downsized from a hospital
- Is located in a rural area or is treated as rural
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles)
- Maintains no more than 25 inpatient beds that can be used for either inpatient or swing-bed services. In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or rehabilitation distinct part unit of up to 10 beds each.
- Maintains an annual average length of stay of 96 hours per beneficiary for acute inpatient care (excluding beds in distinct part units)
- Complies with all CAH Conditions of Participation (CoPs), including the requirement to make available 24-hour emergency care services 7 days per week

Webpage – Critical Access Hospitals Center

https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html
The CAH Center contains helpful links to information on payments, certifications, resources, contacts, education, and manuals of relevance to CAH providers.

Booklet – "Critical Access Hospital"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243364.html
Learn about: background; Critical Access Hospital (CAH) designation; CAH payments and additional Medicare payments; and grants to States under the Medicare Rural Hospital Flexibility Program.

ENROLLMENT

Form – Medicare Enrollment Application Institutional Providers Form CMS-855A

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
A CAH must indicate Critical Access Hospital on the Form CMS-855A or Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibiltites," includes Section 1022A, "AO Reporting Requirements."

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes the following CAH sections:

- 2254A: Statutory Citation
- 2254B: Regulatory Citation
- 2254C: Submission of a State Plan
- 2254D: Requirements for Critical Access Hospitals
- 2255: SA Procedures for CAH Approval
- 2255A: CAH Applications
- 2255B: Pre-Survey Activity
- 2255C: Arranging a CAH Survey
- 2255D: Onsite Survey Activity
- 2255E: Preparing a Statement of Deficiencies
- 2256: RO Procedures for CAH Approval
- 2256A: Verification Criteria
- 2256B: Notification
- 2256C: Effective Dates
- 2256D: RO Processing Complaints Against a CAH
- 2256E: RO Processing Denials or Terminations of a CAH
- 2256F: Relocation of CAHs with a Grandfathered Necessary Provider Designation
- 2256G: Co-Location of Critical Access Hospitals
- 2256H: Off-Campus CAH Facilities
- 2257: CAH Anti-Dumping Requirements
- 2258: Advance Directive Requirements for CAHS
- 2259: Procedures for Processing CAH Swing-Bed Applications
- 2259A: Definition, Authority and Requirements for CAH Providers of Extended Care Services ("Swing-Beds")
- 2259B: Request from a Medicare Participating CAH to add Swing-bed Approval
- 2259C: Pre-Survey Activity
- 2259D: Certificate Of Need (CON) Approval
- 2260: Survey Procedures for Swing-Bed Approval
- 2261: Post-Survey Procedures for Swing-Bed CAHS
- 2262: RO Approval Procedures for Swing-Bed Approval

IOM – "State Operations Manual," Pub. 100-07, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c03.pdf
Chapter 3, "Additional Program Activities", includes several references to CAHs, such as termination and appeal as well as change in size. Sections that apply to CAHs include:

- 3012.1: Termination of Psychiatric Hospitals
- 3034C: For Hospitals, CAHs, and SNFs
- 3100: Hospitals and Hospital Units Excluded From PPS – Annual Self-Attestation
- 3102: General Information on IPPS Exclusion Deemed Providers and Suppliers
- 3104A: Psychiatric Hospitals
- 3104B: Rehabilitation Hospitals

- 3104C: Children's Hospitals
- 3104D: Long-Term Hospitals
- 3104E: Hospital within Hospitals
- 3106: Criteria for Psychiatric and Rehabilitation Units
- 3106A: General Criteria for Units
- 3106B: Specific Criteria for Psychiatric Units
- 3106C: Specific Criteria for Rehabilitation Units
- 3108: SA First-Time Verification Procedures for Hospitals and Units
- 3108A: Rehabilitation Hospitals and Rehabilitation Units of Hospitals
- 3108B: Psychiatric Units of Hospitals
- 3110A: Annual Reverification Process for Nonaccredited, PPS-Excluded, Rehabilitation Hospitals and Units
- 3110B: Reverification Process for Rehabilitation Hospitals and/or Units Accredited by CARF Under CIRP or JCAHO
- 3110C: Reverification Process for Psychiatric Units of Hospitals
- 3112: RO Procedures for Exclusion from PPS for Hospitals and Units
- 3112.1: RO Procedures for First-Time Exclusion of Hospitals and Units
- 3112.2A: Self-Attestation Procedures for PPS-Excluded Hospitals and Units
- 3112.2B: RO Verifying Exclusion Eligibility of Other Facilities
- 3112.3: Role of FIs in Reverification of PPS Excluded Hospitals and Units

IOM – "State Operations Manual," Pub. 100-07, Appendix W

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
Appendix W is entitled "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs."

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Hospitals

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals.html
This webpage provides information about CAH CoPs in the Code of Federal Regulations (CFR). Links related to CAHs are under the Related Links section of this page.

Webpage – Survey & Certification – Certification & Compliance – Critical Access Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.html
This webpage provides basic information about being certified as a Medicare and/or Medicaid CAH and includes links to applicable laws, regulations, and compliance information.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Critical Access Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/CAHs.html
This webpage explains that survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys and includes links to other CAH resources.

COVERAGE

Inpatient Hospital Services

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 1, "Definition of Inpatient Hospital Services," which provides information about CAH inpatient services.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections relevant to coverage:

- 30: Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)
- 30.1: Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

Post-hospital Skilled Nursing Facility (SNF) Care: Swing Beds

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 30, "Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)," which provides information on CAH Swing Bed coverage.

Distinct Part Inpatient Psychiatric and Rehabilitation Units

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 30, "Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)," which lists requirements for CAH distinct part units.

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes Section 2256F, "Relocation of CAHs With a Grandfathered Necessary Provider Designation," which explains that CAH distinct part units are subject to hospital rather than CAH CoPs.

Hospice Care

Letter – Hospice Admissions to a Critical Access Hospital

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/downloads/HospiceAdmissions.pdf
The purpose of this letter is to clarify the application of the 96-hour annual average length of stay limitation for CAHs.

Off Campus Facility

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Section 2256H of Chapter 2, "The Certification Process," is entitled, "Off-Campus CAH Facilities," and includes applicable requirements.

Observation Beds

Letter – Provision of Observation Services in Critical Access Hospitals (CAHs)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter08-16.pdf
This memorandum addresses several aspects of CAH provision of observation services.

BILLING

More Resources: Refer to the Medicare Learning Network® booklet titled "Medicare Billing Information for Rural Providers and Suppliers" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html for more information regarding billing for rural services.

MLN Matters® Article – MM8030 Revised "Medicare System Update to Include Rendering Line Level National Provider Identifiers (NPIs) for Primary Care Incentive Program (PCIP) Payments to Critical Access Hospitals (CAHs)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8030.pdf
This MLN Matters® article describes changes to Medicare systems to identify line level National Provider Identifier (NPI) information for purposes of Primary Care Incentive Program (PCIP) payments to CAHs reimbursed under the optional method.

PART A

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections with specific reference to CAHs:

- 10.3: Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider
- 50.1.2: Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claim Format and Form CMS-1450
- 50.3.1: Background
- 140.1: Threshold Edit for Outpatient and Inpatient Part B Claims
- 160.1: Reporting of Taxonomy Codes (Institutional Providers)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections with CAH billing information:

- 30.1.1: Payment for Inpatient Services Furnished by a CAH
- 200.2: Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

PART B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," provides the following sections about CAH outpatient billing:

- 250: Special Rules for Critical Access Hospital Outpatient Billing
- 250.1: Standard Method – Cost-Based Facility Services, With Billing of A/B MAC (B) for Professional Services
- 250.1.1: Special Instructions for Non-covered Time Increments in Standard Method Critical Access Hospitals (CAHs)

- 250.2: Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services
- 250.2.1: Billing and Payment in a Physician Scarcity Area (PSA)
- 250.2.2: Zip Code Files
- 250.3: Payment for Anesthesia in a Critical Access Hospital
- 250.3.1: Anesthesia File
- 250.3.2: Physician Rendering Anesthesia in a Hospital Outpatient Setting
- 250.3.3: Anesthesia and CRNA Services in a Critical Access Hospital (CAH)
- 250.3.3.1: Payment for CRNA Pass-Through Services
- 250.3.3.2: Payment for Anesthesia Services by a CRNA (Method II CAH only)
- 250.4: CAH Outpatient Services Part B Deductible and Coinsurance
- 250.5: Medicare Payment for Ambulance Services Furnished by Certain CAHs
- 250.6: Clinical Diagnostic Laboratory Tests Furnished by CAHs
- 250.7: Payment for Outpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH
- 250.8: Coding for Administering Drugs in a Method II CAH
- 250.8.1: Coding for Low Osmolar Contrast Material (LOCM)
- 250.8.2: Coding for the Administration of Other Drugs and Biologicals
- 250.9: Coding Assistant at Surgery Services Rendered in a Method II CAH
- 250.9.1: Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery
- 250.9.2: Payment of Assistant at Surgery Services Rendered in a Method II CAH
- 250.9.3: Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
- 250.9.4: Assistant at Surgery Services in a Method II CAH Teaching Hospital
- 250.9.5: Review of Supporting Documentation for Assistants at Surgery Services in a Method II CAH
- 250.10: Coding Co-surgeon Services Rendered in a Method II CAH
- 250.10.1: Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons
- 250.10.2: Payment of Co-surgeon Services Rendered in a Method II CAH
- 250.10.3: Co-surgeon Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
- 250.10.4: Review of Supporting Documentation for Co-surgeon Services in a Method II CAH
- 250.11: Coding Bilateral Procedures Performed in a Method II CAH
- 250.11.1: Use of Payment Policy Indicators for Determining Bilateral Procedures Eligible for 150 Percent Payment Adjustment
- 250.11.2: Payment of Bilateral Procedures Rendered in a Method II CAH
- 260.1: Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
- 260.1.1: Bill Review for Partial Hospitalization Services Received in Community Mental Health Centers (CMHC)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes several references to CAHs. Search for CAH in this chapter in order to identify relevant billing and payment information.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 19

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf
Chapter 19, "Indian Health Services," includes information about Indian Health Services (IHS) CAHs.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 20

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf
Chapter 20, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)," includes Section 01, "Foreword," which states that CAHs may bill for DMEPOS, usually only for outpatients.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," includes Section 75, "General Instructions for Completion of Form CMS-1450 for Billing." This section includes instructions for billing using Form CMS-1450 or its electronic equivalent and explains in Form Locator (FL) 45 that CAHs are not required to report line item dates of service on outpatient bills containing revenue codes, procedure codes or drug codes. This includes claims where the from and through dates are equal. In FL 78 and 79, CAHs must include information about the rendering provider when billing for facility and professional fees.

CLAIMS PROCESSING AND PAYMENT

PART A

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections relevant to CAH payment:

- 30: Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)
- 30.1: Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units
- 30.1.1: Payment for Inpatient Services Furnished by a CAH
- 30.1.1.1: Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH
- 30.1.2: Payment for Post-Hospital SNF Care Furnished by a CAH
- 30.1.3: Costs of Emergency Room On-Call Providers
- 30.1.4: Costs of Ambulance Services
- 140: Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
- 140.3: Billing Requirements Under IRF PPS
- 190.1: Background
- 190.2: Statutory Requirements
- 190.3: Affected Medicare Providers
- 190.5.5: Variable Per Diem Adjustments
- 190.6.4: Emergency Department (ED) Adjustment
- 190.6.4.1: Source of Admission for IPF PPS Claims for Payment of ED Adjustment
- 190.11: Benefit Application and Limits-190 Days
- 200: Electronic Health Record (EHR) Incentive Payments
- 200.1: Payment Calculation

PART B

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
CAH payment is discussed in the same sections of Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," as those listed previously in the Part B billing section of this pathway.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 16

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
Chapter 16, "Laboratory Services," includes information on outpatient laboratory services provided in the following sections:

- 40.3: Hospital Billing Under Part B
- 40.3.1: Critical Access Hospital (CAH) Outpatient Laboratory Service
- 50.3: Hospitals

- 50.3.1: Hospital-Leased Laboratories
- 50.3.2: Hospital Laboratory Services Furnished to Nonhospital Patients

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 18

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
Chapter 18, "Preventive and Screening Services," includes several references to CAHs. Search for CAH in this chapter in order to identify relevant billing and payment information.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 19

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf
Chapter 19, "Indian Health Services," includes information about IHS CAHs.

Fact Sheet – "Rehabilitation Therapy Information Resource for Medicare"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244977.html
This fact sheet is designed to provide education on rehabilitation therapy services. It includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 200.1, "Scope of the Instructions," which references CAHs.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the terms CAH and Critical Access Hospital for related questions and answers. For example, FAQ2873 addresses Electronic Health Records (EHR) incentive programs for CAHs.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about CAHs. Use the search feature on the home page of this website to review these.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data

can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Webpage – Open Door Forums – Rural Health Open Door Forum

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_RuralHealth.html
The Rural Health Open Door Forum (ODF) addresses Rural Health Clinic (RHC), CAH and Federally Qualified Health Center (FQHC) issues, as well as some inclusion of other questions and concerns that occur in clinical practice pertaining to other CMS payment systems that also extend into these settings.

INPATIENT PSYCHIATRIC FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Inpatient Psychiatric Facility Medicare resources.

DEFINITION: INPATIENT PSYCHIATRIC FACILITY (IPF)

An IPF is certified under Medicare as an inpatient psychiatric hospital, which means an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill beneficiary, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit of an acute hospital or Critical Access Hospital (CAH) may also be certified if it meets the clinical record and staffing requirements for a psychiatric hospital.

Booklet – "Discharge Planning"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908184.html
This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

More Resources: Refer to the Hospital pathway for additional information on providing services to Medicare beneficiaries.

ENROLLMENT

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes the following sections about psychiatric hospitals/units:

- 10.6.4: Determining Payment for Services Furnished After Termination of Provider Agreement
- 20: Hospital Defined
- 20.2: Definition of an Emergency Services Hospital
- 20.3: Psychiatric Hospital
- 20.4: Certification of Parts of Institutions as Hospital
- 20.5: Part of a Psychiatric Institution as a Psychiatric Hospital
- 20.6: General Hospital Facility of Psychiatric Hospital
- 20.7: Part of a General Hospital as a Psychiatric Hospital

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf

Chapter 15, "Medicare Enrollment," includes Section 15.4.1.8, "Hospitals and Hospital Units," which explains that, although a psychiatric unit receives a State survey, a separate provider agreement and enrollment is not required.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes Section 2020 titled, "Hospitals – Definition and Citations," which provides a reference to the law that defines Medicare eligible psychiatric hospitals.

IOM – "State Operations Manual," Pub. 100-07, Appendix A and Appendix AA

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf and https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/som107ap_aa_psyc_hospitals.pdf
Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors. The modules for Prospective Payment System (PPS)-exempt psychiatric units and psychiatric hospitals are attached to Appendix A. If the hospital is a psychiatric hospital and if the survey team will be assessing the hospital's compliance with both the hospital Conditions of Participation (CoPs) and psychiatric hospital special conditions, the team will use the psychiatric hospital module in addition to the hospital protocol to conduct the survey. Appendix AA, "Psychiatric Hospitals – Interpretative Guidelines and Survey Procedures," gives detailed instructions on how surveyors perform these tasks to assess the two special CoPs for psychiatric hospitals.

Webpage – Survey & Certification – General Information – Accreditation of Medicare Certified Providers & Suppliers

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html
This webpage provides information on Accreditation Organizations (AOs) and a list of organizations qualified to provide accreditation to hospitals enrolled in the Medicare Program.

Webpage – Survey & Certification – Certification & Compliance – Psychiatric Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PsychHospitals.html
This webpage provides basic information about being certified as a Medicare psychiatric hospital provider and includes links to the psychiatric hospital sections of Chapter 2, "The Certification Process," of the "State Operations Manual," Guidance for Laws and Regulations for Psychiatric Hospitals, and relevant sections of the Code of Federal Regulations (CFR) and Social Security Act.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Psychiatric Hospitals

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/PsychHospital.html
This webpage explains survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of survey findings.

This webpage provides links to Appendix AA of the "State Operations Manual" and to the Certification and Compliance for Psych Hospitals webpage.

Transmittal – 81 "Revisions to State Operations Manual (SOM), Appendix A, Hospitals"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81SOMA.pdf
This transmittal covers information on who may provide certain services in a hospital.

Form – CMS-724 "Medicare/Medicaid Psychiatric Hospital Survey Data"

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS724.pdf
Section I of this form is to be completed by the IPF.

COVERAGE

IOM – "Medicare General Information, Eligibiltiy, and Entitlement Manual," Pub. 100-01, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
Chapter 4, "Physician Certification and Recertification of Services," includes Section 10.9, "Inpatient Psychiatric Facility Services Certification and Recertification."

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c02.pdf
Chapter 2, "Inpatient Psychiatric Hospital Services," includes the following sections about IPF coverage:

- 10: Inpatient Psychiatric Facility Services
- 10.1: Background
- 10.2: Statutory Requirements
- 10.3: Affected Medicare Providers
- 20: Admission Requirements
- 30: Medical Records Requirements
- 30.1: Development of Assessment/Diagnostic Data
- 30.2: Psychiatric Evaluation
- 30.2.1: Certification and Recertification Requirements
- 30.2.1.1: Certification
- 30.2.1.2: Recertification
- 30.2.2: Active Treatment
- 30.2.2.1: Principals for Evaluating a Period of Active Treatment
- 30.2.3: Services Supervised and Evaluated by a Physician
- 30.3: Treatment Plan
- 30.3.1: Individualized Treatment or Diagnostic Plan
- 30.3.2: Services Expected to Improve the Condition or for Purpose of Diagnosis
- 30.4: Recording Progress
- 30.5: Discharge Planning and Discharge Summary
- 40: Personnel Requirements
- 40.1: Director of Inpatient Psychiatric Services Medical Staff
- 40.2: Nursing Services
- 50: Psychological Services
- 60: Social Services
- 70: Therapeutic Activities
- 80: Benefit Application
- 90: Benefits Exhaust

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c04.pdf
Chapter 4, "Inpatient Psychiatric Benefit Days Reduction and Lifetime Limitation," has the following sections regarding coverage:

- 10: Inpatient Psychiatric Benefit Days Reduction
- 10.1: Patient Status on Day of Entitlement
- 10.2: Institution's Status in Determining Days Deducted
- 20: Days of Admission, Discharge, and Leave
- 30: Reduction for Psychiatric Services in General Hospitals
- 40: Determining Days Available
- 50: Inpatient Psychiatric Hospital Services – Lifetime Limitation

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes Section 190.11, "Benefit Application and Limits-190 Days."

Booklet – "Mental Health Services"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246600.html
This booklet is designed to provide education on mental health services. It includes the following information: covered and non-covered mental health services, eligible professionals, outpatient and inpatient psychiatric hospital services, same day billing guidelines, and National Correct Coding Initiative.

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections about IPF billing:

- 40.4: Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement
- 50.1.3: Signature on the Request for Payment by Someone Other Than the Patient
- 90: Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections about IPF billing:

- 190.10.1: General Rules
- 190.10.2: Billing Period
- 190.10.3: Patient Status Coding
- 190.10.4: Reporting ECT Treatments
- 190.10.5: Outpatient Services Treated as Inpatient Services
- 190.10.6: Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period
- 190.10.7: Billing for Interrupted Stays
- 190.10.8: Grace Days
- 190.10.9: Billing Stays Prior to and Discharge After PPS Implementation Date
- 190.10.10: Billing Ancillary Services Under IPF PPS
- 190.10.11: Covered Costs Not Included in IPF PPS Amount
- 190.10.12: Same Day Transfer Claims

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," includes Section 75.3, "Form Locators 31-41," includes Inpatient Rehabilitation/Psychiatric Facility (IR\PF) information for Form Locators (FLs) 35 and 36, Occurrence Span Code and Dates.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections relevant to IPF payment:

- 190: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
- 190.1: Background
- 190.2: Statutory Requirements
- 190.3: Affected Medicare Providers
- 190.4: Federal Per Diem Base Rate
- 190.4.1: Standardization Factor
- 190.4.2: Budget Neutrality
- 190.4.2.1: Budget Neutrality Components
- 190.4.3: Annual Update
- 190.4.4: Calculating the Federal Payment Rate
- 190.5: Patient-Level Adjustments
- 190.5.3: Comorbidity Adjustments
- 190.5.4: Age Adjustments
- 190.5.5: Variable Per Diem Adjustments
- 190.6: Facility-Level Adjustments
- 190.6.1: Wage Index
- 190.6.2: Rural Location Adjustment
- 190.6.3: Teaching Status Adjustment
- 190.6.4: Emergency Department (ED) Adjustment
- 190.7: Other Payment Policies
- 190.7.1: Interrupted Stays
- 190.7.2: Outlier Policy
- 190.7.2.1: How to Calculate Outlier Payments
- 190.7.2.2: Determining the Cost-to-Charge Ratio
- 190.7.2.3: Outlier Reconciliation
- 190.7.3: Electroconvulsive Therapy (ECT) Payment
- 190.7.4: Stop Loss Provision (Transition Period Only)
- 190.8: Transition (Phase-In Implementation)
- 190.8.1: Implementation Date for Provider
- 190.9: Definition of New IPF Providers Versus TEFRA Providers
- 190.9.1: New Providers Defined
- 190.10: Claims Processing Requirements Under IPF PPS
- 190.11: Benefit Application and Limits-190 Days
- 190.12: Beneficiary Liability
- 190.13: Periodic Interim Payments (PIP)
- 190.14: Intermediary Benefit Payment Report (IBPR)
- 190.15: Monitoring Implementation of IPF PPS Through Pulse
- 190.16: IPF PPS System Edits
- 190.17: IPF PPS PRICER Software

Paper-Based Manual – "Provider Reimbursement Manual – Part 1," Pub. 15-1, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 30, "NON-PPS Hospitals and Distinct Part Units," includes information relevant to IPFs.

Webpage – Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html
This webpage provides information on how IPF PPS payments are determined under the IPF PPS using a base rate with the possibility of various adjustments, of which the Medicare Severity Diagnosis Related Group (MS-DRG) adjustment is one.

Webpage – PC-Pricer – Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC PRICER

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inppsy.html
This webpage provides information on payment calculations applicable under IPF PPS including all payments, adjustments, and outlier adjustments.

Fact Sheet – "Inpatient Psychiatric Facility Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243666.html
This fact sheet is designed to provide education on the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). It includes the following information: background, coverage requirements, how payment rates are set, fiscal year 2015 update to the IPF PPS, and IPF Quality Reporting Program.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 200.1, "Scope of the Instructions," which references IPFs.

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Inpatient Psychiatric Facility PPS – IPF PPS Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/IPF-PPS-Regulations-and-Notices.html
This webpage provides links to applicable laws and regulations related to the inpatient psychiatric benefit provided by Medicare, the specific payment policies under the IPF PPS, and the requirements for inpatient services of psychiatric hospitals. It also provides links to basic information, laws, regulations, and compliance information related to being certified as a Medicare and/or Medicaid IPF.

Webpage – Inpatient Psychiatric Facility PPS – Inpatient Psychiatric Facility PPS Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Inpatient-Psychiatric-Facility-PPS-Transmittals.html
This webpage shows the transmittals that are directed to the IPF PPS provider community, but the list may not include all instructions for which IPF PPS providers are responsible. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term IPF for related questions and answers. For example, FAQ1953 addresses whether the Centers for Medicare & Medicaid Services (CMS) requires daily medical director notes in the IPF setting.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about IPFs. Use the search feature on the home page of this website to review these.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Beneficiary Booklet – "Medicare & Your Mental Health Benefits"

https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf
This booklet provides information on Medicare's coverage and payment of mental health services.

Electronic Mailing List – IPF PPS

https://list.nih.gov/cgi-bin/wa.exe?A0=IPFPPS-L
The IPF PPS electronic mailing list is administered by CMS, which emails subscribers information regarding IPF PPS policy, publications, coding, payment, and educational material.

INPATIENT REHABILITATION FACILITY

INTRODUCTION

This curriculum is designed as a pathway to Inpatient Rehabilitation Facility Medicare resources.

DEFINITION: INPATIENT REHABILITATION FACILITY (IRF)

An IRF is an inpatient rehabilitation hospital or a rehabilitation unit of an acute care hospital. An IRF provides intensive rehabilitation therapy in a resource intensive inpatient hospital environment for beneficiaries who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF, the intensity of rehabilitation therapy services, and high level of physician supervision.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.8, "Hospitals and Hospital Units," which explains that, although a rehabilitation unit receives a State survey, a separate provider agreement and enrollment is not required.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections about IRF criteria that must be met:

- 140: Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
- 140.1: Medicare IRF Classification Requirements
- 140.1.1: Criteria That Must Be Met By Inpatient Rehabilitation Facilities
- 140.1.2: Additional Criteria That Must Be Met By Inpatient Rehabilitation Units
- 140.1.3: Verification Process Used to Determine if the Inpatient Rahabilitation Facility Met the Classification Criteria
- 140.1.4: New IRFs
- 140.1.5: Changes in the Status of an IRF Unit
- 140.1.6: New IRF Beds
- 140.1.7: Change of Ownership or Leasing
- 140.1.8: Mergers
- 140.1.9: Retroactive Adjustments For Provisionally Excluded IRFs or IRF Beds

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes Section 2020, "Hospitals – Definition and Citations," which defines a hospital as an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services, or rehabilitation services.

IOM – "State Operations Manual," Pub. 100-07, Appendix A

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors. The modules for Acute Inpatient Prospective Payment System (AIPPS)-exempt rehabilitation units and rehabilitation hospitals are attached to Appendix A. If the hospital is a rehabilitation hospital and if the survey team will be assessing the hospital's compliance with both the hospital Conditions of Participation (CoPs) and rehabilitation hospital special conditions, the team will use the rehabilitation hospital module in addition to the hospital protocol to conduct the survey.

Webpage – Survey & Certification – Certification & Compliance – Inpatient Rehabilitation Facilities

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/InpatientRehab.html
This webpage provides basic information about being certified as a Medicare and/or Medicaid IRF and includes links to the hospital definitions section of Chapter 2 of the "State Operations Manual," Guidance for Laws and Regulations for Inpatient Rehab Providers webpage, and relevant sections of the Code of Federal Regulations (CFR) and Social Security Act.

Webpage – Inpatient Rehabilitation Facility PPS – IRF Classification Criteria

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html
This webpage describes the procedures whereby Regional Offices and Fee-For-Service (FFS) Contractors determine whether facilities qualify as IRFs.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," provides the following sections about IRF coverage:

- 110: Inpatient Rehabilitation Facility (IRF) Services
- 110.1: Documentation Requirements
- 110.1.1: Required Preadmission Screening
- 110.1.2: Required Post-Admission Physician Evaluation
- 110.1.3: Required Individualized Overall Plan of Care
- 110.1.4: Required Admission Orders
- 110.1.5: Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- 110.2: Inpatient Rehabilitation Facility Medical Necessity Criteria
- 110.2.1: Multiple Therapy Disciplines
- 110.2.2: Intensive Level of Rehabilitation Services
- 110.2.3: Ability to Actively Participate in Intensive Rehabilitation Therapy Program
- 110.2.4: Physician Supervision
- 110.2.5: Interdisciplinary Team Approach to the Delivery of Care
- 110.3: Definition of Measurable Improvement

Webpage – Inpatient Rehabilitation Facility PPS – Coverage Requirements

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html
This webpage includes up-to-date instructions for determining and documenting the medical necessity of IRF admissions.

Fact Sheet – "Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246727.html
This fact sheet is designed to provide education on Comprehensive Error Rate Testing (CERT) program errors related to inpatient rehabilitation services. It includes common errors identified through the CERT Review Process and information on the documentation needed to support a claim submitted to Medicare for inpatient rehabilitation services.

BILLING

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following section specific to IRF billing.

- 50.2.1: Inpatient Billing From Hospitals and SNFs
- 60.2: Noncovered Charges on Inpatient Bills
- 90: Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
- 160.1: Reporting of Taxonomy Codes (Institutional Providers)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following Section 140.3, "Billing Requirements Under IRF PPS."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," includes Section 75.3, "Form Locators 31-41," includes IRF information for Form Locators (FLs) 35 and 36, Occurrence Span Code and Dates.

Webpage – Inpatient Rehabilitation Facility PPS – IRF Patient Assessment Instrument

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html
This webpage provides a list of important items associated with the IRF PAI, along with downloadable software related to the submission of IRF PAI data.

Form – "Inpatient Rehabilitation Facility-Patient Assessment Instrument" (Form CMS-10036)

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10036.pdf
IRFs submit this form for each Medicare Fee-For-Service beneficiary.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections specific to IRF payment:

- 140.2: Payment Provisions Under IRF PPS
- 140.2.1: Phase-In Implementation
- 140.2.2: Payment Adjustment Factors and Rates
- 140.2.3: Case-Mix Groups
- 140.2.4: Case-Level Adjustments
- 140.2.5: Facility-Level Adjustments
- 140.2.5.1: Area Wage Adjustments
- 140.2.5.2: Rural Adjustment
- 140.2.5.3: Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI) Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)
- 140.2.5.4: Teaching Status Adjustment
- 140.2.5.4.1: FTE Resident Cap
- 140.2.5.5: Outliers
- 140.2.6: Cost-to-Charge Ratios
- 140.2.7: Use of a National Average Cost-to-Charge Ratio
- 140.2.8: Reconciling Outlier Payments for IRF
- 140.2.9: Time Value of Money
- 140.2.10: Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs
- 140.2.11: Quality Reporting Program
- 140.3.1: Shared Systems and CWF Edits
- 140.3.2: IRF PPS Pricer Software
- 140.3.3: Remittance Advices
- 140.3.4: Payment Adjustment for Late Transmission of Patient Assessment Data

Paper-Based Manual – "The Provider Reimbursement Manual (Part 1)," Pub. 15-1, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 30, "NON-PPS Hospitals and Distinct Part Units," includes information relevant to IRFs.

Webpage – Inpatient Rehabilitation Facility (IRF) PPS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html
This webpage provides an overview and links to a spotlight and other Centers for Medicare & Medicaid Services (CMS) webpages relevant to IRF payment.

Webpage – PC Pricer – Inpatient Rehabilitation Facility PPS PC Pricer

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/IRF.html
This webpage includes a link to the "User's Manual" and annual files.

Fact Sheet – "Inpatient Rehabilitation Facility Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243668.html
Learn about background; elements of the Inpatient Rehabilitation Facility (IRF) Prospective Payment System; payment updates; and IRF Quality Reporting Program.

MLN Matters® Article – MM9195 Revised "The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2013 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9195.pdf

This MLN Matters® article provides updated data for determining the disproportionate share adjustment for IPPS hospitals and the low income patient adjustment for IRFs. The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, CMS certification number, SSI days, total Medicare days, and the ratio of Medicare Part A beneficiary days attributable to SSI recipients.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 200.1, "Scope of the Instructions," which references IRFs.

QUALITY

Webpage – Quality Initiatives-General Information

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html
The Downloads section of this webpage includes the 2005 Final Report of "Development of Quality Indicators for Inpatient Rehabilitation Facilities."

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – Inpatient Rehabilitation Facility PPS – List of IRF Federal Regulations

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html
This webpage displays Federal Regulations related to IRF PPS.

Webpage – Inpatient Rehabilitation Facility PPS – IRF Program Transmittals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Program-Transmittals.html
This webpage shows the transmittals that are directed to the IRF PPS provider community, but the list may not include all instructions for which IRF PPS providers are responsible. For a list of all instructions, view the Transmittals webpage under Regulations and Guidance.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued reports about IRFs. Use the search feature on the home page of this website to review these.

Electronic Mailing List – IRF PPS – IRF

https://list.nih.gov/cgi-bin/wa.exe?A0=IRFPPS-L
The IRF electronic mailing list is administered by CMS, which emails subscribers information regarding IRF PPS.

LONG TERM CARE HOSPITAL

INTRODUCTION

This curriculum is designed as a pathway to Long Term Care Hospital Medicare resources.

DEFINITION: LONG TERM CARE HOSPITAL (LTCH)

An LTCH is certified under Medicare as a short-term acute care hospital that has been excluded from the acute care hospital Inpatient Prospective Payment System (IPPS) and, for Medicare payment purposes, is generally defined as having an average inpatient length of stay of greater than 25 days.

Booklet – "Discharge Planning"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908184.html
This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

ENROLLMENT

Letter – Extension of Long-Term Care Hospital (LTCH) Moratorium

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter10_25.pdf
This Center for Medicare & Medicaid Services (CMS) letter to State agencies references the extension of the moratorium.

Form – CMS-671 Long Term Care Facility Application For Medicare and Medicaid

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS671.pdf
This form is to be completed by the LTCH.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

More Resources: An LTCH is certified under Medicare as a short-term acute care hospital. Survey and certification is based on Inpatient Acute Hospital requirements. Refer to the Acute Hospital pathway for more information about hospitals.

COVERAGE

More Resources: Coverage in a LTCH is consistent with coverage of an acute hospital stay. Refer to the Acute Hospital pathway for more information about hospitals.

BILLING

Educational Tool – "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908924.html
Learn about short & long descriptors for each of the 42 non-payable functional G-codes.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," includes the following sections specific to LTCH billing:

- 50.2.1: Inpatient Billing From Hospitals and SNFs
- 50.2.4: Reprocess Inpatient or Hospice Claims in Sequence
- 160.1: Reporting of Taxonomy Codes (Institutional Providers)

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections specific to LTCH billing:

- 150.13: Billing Requirements Under LTCH PPS
- 150.14: Stays Prior to and Discharge After PPS Implementation Date
- 150.14.1: Crossover Patients in New LTCHs
- 150.16: Billing Ancillary Services Under LTCH PPS
- 150.17: Benefits Exhausted
- 150.17.1.1: Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)
- 150.17.1.2: Example 2: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)
- 150.17.1.3: Example 3: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (20 day stay)
- 150.17.1.4: Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)
- 150.17.1.5: Example 5: Only LTR Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)
- 150.19: Interim Billing

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 25

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," includes Section 75.3, "Form Locators 31-41." This section explains Form Locators (FLs) 35 and 36, which LTCHs must use to provide information about the occurrence span code and dates when billing for facility and professional fees.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections about LTCH Prospective Payment System (PPS) claims processing and payment:

- 150.1: Background
- 150.2: Statutory Requirements
- 150.3: Affected Medicare Providers
- 150.4: Revision of the Qualification Criterion for LTCHs
- 150.5: Payment Provisions Under LTCH PPS
- 150.5.1: Budget Neutrality
- 150.5.2: Budget Neutrality Offset
- 150.6: Beneficiary Liability
- 150.7: Patient Classification System
- 150.8: Relative Weights
- 150.9: Payment Rate
- 150.9.1: Case-Level Adjustments
- 150.9.1.1: Short-Stay Outliers
- 150.9.1.2: Interrupted Stays
- 150.9.1.3: Payments for Special Cases
- 150.9.1.4: Payment Policy for Co-Located Providers
- 150.9.1.5: High Cost Outlier Cases
- 150.10: Facility-Level Adjustments
- 150.15: System Edits
- 150.18: Provider Interim Payment (PIP)
- 150.23: LTCH Pricer Software
- 150.23.1: Inputs/Outputs to Pricer
- 150.24: Determining the Cost-to-Charge Ratio

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 30, "NON-PPS Hospitals and Distinct Part Units," includes Section 3001.4, "Long Term Hospitals."

Webpage – Long Term Care Hospital (LTCH) PPS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html
This webpage provides information on the major elements of the LTCH PPS, training material and fact sheets, LTCH PPS regulations, and notices and the LTCH payment system.

Webpage – PC Pricer – Long-Term Care Hospital PPS PC Pricer

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/LTCH.html
This webpage provides LTCH PPS PC Pricer downloads.

Fact Sheet – "Long Term Care Hospital Prospective Payment System"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243395.html
Learn about: Long Term Care Hospital (LTCH) certification; Medicare Severity Long Term Care Diagnosis-Related Groups patient classification; site neutral payment rate, payment policy adjustments, and payment updates; and LTCH Quality Reporting Program.

MLN Matters® Article – MM9195 Revised "The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2013 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9195.pdf
This MLN Matters® article provides updated data for determining the disproportionate share adjustment for IPPS hospitals and the low income patient adjustment for IRFs. The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, CMS certification number, SSI days, total Medicare days, and the ratio of Medicare Part A beneficiary days attributable to SSI recipients.

BENEFICIARY NOTICES

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf
Chapter 30, "Financial Liability Protections," includes Section 200.1, "Scope of the Instructions," which references LTCHs.

QUALITY

Webpage – LTCH Quality Reporting – Long-Term Care Hospital (LTCH) Quality Reporting (QRP)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html
This webpage provides links to quality reporting information on the left side of the page.

Webpage – Quality Initiatives-General Information

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html
The Related Links section of this webpage includes a link to hospital quality initiatives.

Article – "Ventilator-Associated Pneumonia among Elderly Medicare Beneficiaries in Long-Term Care Hospitals"

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/09FallPg1.pdf
This document addresses control of Ventilator-Associated Pneumonia (VAP), which is an important aspect of quality of care improvement for LTCHs since they provide post-acute ventilator care for many Medicare beneficiaries.

OTHER RESOURCES

Other helpful, official resources are included in this section.

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 6

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
Chapter 6, "Medicare Contractor Medical Review Guidelines for Specific Services," includes the following sections about medical review of LTCHs:

- 6.5: Medical Review of Inpatient Hospital Claims

- 6.5.1: Screening Instruments
- 6.5.2: Medical Review of Inpatient Prospective Payment System (IPPS) Hospital and Long Term Care Hospital (LTCH) Claims

Webpage – Long-Term Care Hospital PPS – LTCHPPS Regulations and Notices

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices.html
This webpage is a central source for the Federal regulations and notices for rate years and fiscal years for the LTCHPPS. From this webpage, providers can download the current calendar year's changes to the LTCHPPS (and IPPS).

Webpage – Transmittals

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Use this webpage to search for Transmittals issued for Long-Term Care Hospital providers and topics. On the left side of the page select the year you would like to research, then in the search box enter the topic you are searching for.

Website – Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://www.pepperresources.org
This website is the official site for information, training, and support related to PEPPER.

PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. There are separate user's guides, training & resources for: short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities, and inpatient rehabilitation facilities.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued several reports on LTCHs. Use the search feature on this website to review these.

RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION

INTRODUCTION

This curriculum is designed as a pathway to Religious Nonmedical Health Care Institution Medicare resources.

DEFINITION: RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI)

An RNHCI is a non-for-profit provider enrolled in Medicare to furnish religious nonmedical care or religious method of healing (health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets to fulfill a beneficiary's total health care needs). The law includes an RNHCI in the definition of hospital with respect to certain items and hospital services and includes sanatoria with respect to items and services furnished to inpatients in a long term care setting.

IOM – "Medicare General Information, Eligibility, and Entitlement Manual," Pub. 100-01, Chapter 5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf
Chapter 5, "Definitions," includes Section 40, "Religious Nonmedical Health Care Institution Defined," which lists the 10 qualifying provisions from the law.

ENROLLMENT

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf
Chapter 15, "Medicare Enrollment," includes Section 15.4.1.12, "Religious Non-Medical Health Care Institutions (RNCHIs)."

Webpage – Review Contractor Directory – Interactive Map

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
The Review Contractor Directory – Interactive Map allows you access to state-specific CMS contractor contact information. The Provider Call Center Toll Free Number Directory can be found in the interactive map.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c01.pdf
Chapter 1, "Program Background and Responsibilities," includes Section 1018B, "Religious Nonmedical Health Care Institutions (RNHCIs)."

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," includes Section 2054, "Religious Nonmedical Health Care Institutions (RNHCIs)."

IOM – "State Operations Manual," Pub. 100-07, Appendix U

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_u_rnhci.pdf
Appendix U, "Survey Procedures and Interpretive Guidelines for Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions," includes the survey tag number followed by the wording of the regulation and then guidance to surveyors.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participation (CoPs) – Religious Nonmedical Health Care Institutions

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/RNHCI.html
This page provides Code of Federal Regulations (CFR) references and the following CFR section descriptions:

- The CoPs include beneficiary rights, discharge planning, quality assessment and performance improvement, food services, administration, staffing, physical environment, life safety from fire, and utilization review.
- The CfCs include definitions and terms, valid election requirements, estimate of expenditures and adjustments, and monitoring expenditure level.

Webpage – Survey & Certification – Guidance to Laws & Regulations – Religious Nonmedical Health Care Institutions

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/RNHCI.html
This webpage explains survey protocols and Interpretive Guidelines are established to provide guidance to personnel conducting surveys. It includes links to other RNHCI survey and certification resources.

Webpage – Survey & Certification – Certification & Compliance – Religious Nonmedical Health Care Institutions

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RNHCIs.html
This webpage lists 10 requirements an RNHCI must meet to be certified and provides links to other RNHCI survey and certification resources.

COVERAGE

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes the Section 130.1, "Beneficiary Eligibility for RNHCI Services."

BILLING

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 130.3, "Medicare Payment for RNHCI Services and Beneficiary Liability," which explains that, under normal Medicare rules, a provider of services may only bill a beneficiary deductible and coinsurance amounts. However, total Medicare payments to RNHCIs are subject to limits, and, in the event that Medicare reduces payments to an RNHCI based on these limits, the RNHCI may bill beneficiaries an amount equal to any such reduction.

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf
Chapter 1, "General Billing Requirements," has the following sections regarding RNHCI bills:

- 60.2: Noncovered Charges on Inpatient Bills
- 60.4: Noncovered Charges on Outpatient Bills

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," includes the following sections about claims submission by an RNHCI:

- 170.2: Billing Process for RNHCI Services
- 170.2.1: When to Bill for RNHCI Services
- 170.2.2: Required Data Elements on Claims for RNHCI Services
- 170.3: RNHCI Claims Processing By the Medicare Contractor with RNHCI Specialty Workload
- 170.3.1: RNHCI Claims Not Billed to Orignial Medicare
- 170.4: Informing Beneficiaries of the Results of RNHCI Claims Processing
- 180: Processing Claims For Beneficiaries with RNHCI Elections by Contractors without RNHCI Specialty Workloads

Webpage – Jurisdiction J A/B Medicare Contractor

http://www.cahabagba.com
This webpage for the J A/B Medicare Contractor includes contact and other information relevant to RNHCIs.

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes Section 130.3, "Medicare Payment for RNHCI Services and Beneficiary Liability."

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," contains the following sections relating to RNHCIs:

- 170.3: RNHCI Claims Processing By the Medicare Contractor with RNHCI Specialty Workload
- 180: Processing Claims For Beneficiaries with RNHCI Elections by contractors without RNHCI Specialty Workloads

Paper Manual – "The Provider Reimbursement Manual – Part 1," Pub. 15-1, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 30, "NON-PPS Hospitals and Distinct Part Units," includes information on the Tax Equity and Fiscal Responsibility Act (TEFRA) payment, even though it does not specifically reference RNHCIs.

BENEFICIARY NOTICES

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
Chapter 1, "Inpatient Hospital Services Covered Under Part A," includes the following sections related to beneficiary election of RNHCI benefits:

- 130: Religious Nonmedical Health Care Institution (RNHCI) Services

- 130.1: Beneficiary Eligibility for RNHCI Services
- 130.2: Election of RNHCI Benefits
- 130.2.1: Revocation of RNHCI Election
- 130.2.2: RNHCI Election After Prior Revocation

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

Chapter 3, "Inpatient Hospital Billing," includes the following sections about beneficiary elections:

- 170: Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI) Claims
- 170.1: RNHCI Election Process
- 170.1.1: Requirement for RNHCI Election
- 170.1.2: Revocation of RNHCI Election
- 170.1.3: Completion of the Notice of Election for RNHCI
- 170.4: Informing Beneficiaries of the Results of RNHCI Claims Processing
- 180.1: Recording Determinations of Excepted/Nonexcepted Care on Claim Records
- 180.2: Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 30

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf

Chapter 30, "Financial Liability Protections," includes Section 200.1, "Scope of the Instructions," which references RNHCIs.

IOM – "State Operations Manual," Pub. 100-07, Appendix U

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_u_rnhci.pdf

Appendix U, "Survey Procedures and Interpretive Guidelines for Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions," includes information about beneficiary election of RNHCI.

TRANSPLANT CENTER

INTRODUCTION

This curriculum is designed as a pathway to Transplant Center Medicare resources.

DEFINITION: TRANSPLANT CENTER

A transplant program is defined as a component within a transplant hospital that provides transplantation of a particular type of organ. Types of organ transplant programs include:

- Heart, Lung, Heart/Lung (A heart/lung program must be located in a hospital with an existing Medicare-approved heart and Medicare-approved lung program.)
- Liver, Intestine (An intestine program must be located in a hospital with a Medicare-approved liver program. The program includes multivisceral and combined liver-intestine transplants.)
- Kidney, Pancreas (A pancreas program must be located in a hospital with a Medicare-approved kidney program. The program includes combined kidney/pancreas transplants.)

This pathway addresses only policies relevant to Centers for Medicare & Medicaid Services (CMS)-approved transplant centers; for example, stem cell or bone marrow policies are not included.

More Resources: Refer to the Hospital pathway for more information about transplant-related hospital requirements and to the End-Stage Renal Disease (ESRD) Facility pathway for ESRD-specific information.

ENROLLMENT

IOM – "Medicare Claims Processing Manual" Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," Section 90, "Billing Transplant Services," includes the address to which an application should be sent.

ACCREDITATION STANDARDS/SURVEY & CERTIFICATION

IOM – "State Operations Manual," Pub. 100-07, Chapter 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf
Chapter 2, "The Certification Process," provides information on the certification process for renal transplantation centers.

IOM – "State Operations Manual," Pub. 100-07, Appendix A

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," includes information about transplantation with the survey tag number followed by the wording of the regulation and then guidance to surveyors.

Webpage – Survey & Certification – Certification & Compliance – Transplant

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html
This webpage provides basic information about Medicare approval for organ transplant centers and includes links to applicable laws, regulations, compliance information, and a listing of currently approved programs. The Downloads section of this page provides a link to items requested from Transplant Programs during the onsite survey.

Webpage – Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) – Transplant Centers

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/transplantcenters.html
This webpage includes a listing of Code of Federal Regulations (CFR) that pertain to transplant centers, as well as a link to the Final Rule for Hospital CoPs and requirements for approval and re-approval of transplant centers to perform organ transplants.

Document – Organ Transplant Program Application Update

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/Combinedappinfo.pdf
This document shows the required information for applications for approval.

COVERAGE

IOM – "Medicare General Information, Eligibility, and Entitlement," Pub. 100-01, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf
Chapter 1, "General Overview," includes Section 10.3, "Supplementary Medical Insurance (Part B) – A Brief Description," which explains that Medicare covers prescription drugs used in immunosuppressive therapy furnished to a beneficiary who receives a covered organ transplant for which payment is made under Medicare Part A or B.

IOM – "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
Chapter 15, "Covered Medical and Other Health Services," Section 50, "Drugs and Biologicals," includes information regarding immunosuppressive drug coverage.

IOM – "Medicare National Coverage Determinations (NCD) Manual," Pub. 100-03, Chapter 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Chapter 1, "Coverage Determinations," includes reference to transplant in a specific NCD. There might be other NCDs of interest in this manual. NCDs may also be found by using the searchable Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database, which will also include Local Coverage Determinations (LCDs) by Medicare Contractors.

Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf
- 20.3: Thoracic Duct Drainage (TDD) in Renal Transplants
- 20.9: Artificial Hearts And Related Devices

Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf
- 110.23: Stem Cell Transplantation

Part 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf

- 190.1: Histocompatibility Testing
- 190.11: Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management – (Effective March 19, 2008)
- 190.12: Urine Culture, Bacterial
- 190.32: Gamma Glutamyl Transferase
- 190.33: Hepatitis Panel/Acute Hepatitis Panel

Part 4

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

- 260: Transplantation – Solid Organ Transplants
- 260.1: Adult Liver Transplantation
- 260.2: Pediatric Liver Transplantation
- 260.3: Pancreas Transplants (Effective April 26, 2006)
- 260.3.1: Islet Cell Transplantation in the Context of A Clinical Trial
- 260.5: Intestinal and Multi-Visceral Transplantation (Effective May 11, 2006)
- 260.6: Dental Examination Prior to Kidney Transplantation
- 260.7: Lymphocyte Immune Globulin, Anti-Thymocyte Globulin (Equine)
- 260.9: Heart Transplants
- 260.10: Heartsbreath Test for Heart Transplant Rejection (Effective December 8, 2008)

BILLING

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

Chapter 3, "Inpatient Hospital Billing," includes the following sections about hospital billing of transplant services:

- 90: Billing Transplant Services
- 90.1: Kidney Transplant – General
- 90.1.1: The Standard Kidney Acquisition Charge
- 90.1.2: Billing for Kidney Transplant and Acquisition Services
- 90.1.3: Billing for Donor Post-Kidney Transplant Complication Services
- 90.2: Heart Transplants
- 90.3: Stem Cell Transplantation
- 90.3.1: Allogeneic Stem Cell Transplantation
- 90.3.2: Autologous Stem Cell Transplantation (AuSCT)
- 90.3.3: Billing for Stem Cell Transplantation
- 90.4: Liver Transplants
- 90.4.1: Standard Liver Acquisition Charge
- 90.4.2: Billing for Liver Transplant and Acquisition Services
- 90.5: Pancreas Transplants With Kidney Transplants
- 90.5.1: Pancreas Transplants Alone (PA)
- 90.6: Intestinal and Multi-Visceral Transplants

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf

Chapter 17, "Drugs and Biologicals," includes the following sections about immunosuppressive drug billing:

- 80.3: Billing for Immunosuppressive Drugs
- 80.3.1: Requirements for Billing A/B MAC (A) for Immunosuppressive Drugs

CLAIMS PROCESSING AND PAYMENT

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapter 3

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
Chapter 3, "Inpatient Hospital Billing," Section 20, "Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)," provides payment information regarding organ acquisition costs.

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-1, Chapter 27

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html
Chapter 27, "ESRD Services and Supplies," provides payment information.

Paper-Based Manual – "The Provider Reimbursement Manual-Part 1," Pub. 15-2, Chapter 36

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
Chapter 36, "Hospital and Hospital Healthcare Complex Cost Reports Form CMS-2552-96," includes information about "Worksheet D-6, Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers."

OTHER RESOURCES

Other helpful, official resources are included in this section.

Webpage – CMS Frequently Asked Questions

https://questions.cms.gov
This Frequently Asked Questions (FAQs) webpage allows providers to ask questions related to Medicare. Search under the term transplant for related questions and answers. For example, FAQ3457 addresses the onset of dialysis.

Website – Office of Inspector General, U.S. Department of Health and Human Services

https://oig.hhs.gov
The Office of Inspector General (OIG) has issued information regarding transplant centers. Use the search feature on the home page of this website to review these.

Webpage – Organ Procurement and Transplantation Network

https://optn.transplant.hrsa.gov/
The Organ Procurement and Transplantation Network (OPTN) is the unified transplant network established by the United States Congress under the National Organ Transplant Act (NOTA) of 1984. The act called for the network to be operated by a private, non-profit organization under Federal contract.

Webpage – Donate the Gift of Life

http://www.organdonor.gov/index.html
This webpage explains about organ donation and transplantation.

Beneficiary Booklet – "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services"

https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf
This booklet has information about Medicare coverage for people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Beneficiary Publication – "Filing a Complaint Concerning Dialysis or Kidney Transplant Care"

https://www.medicare.gov/Pubs/pdf/11314.pdf
This fact sheet provides information about filing complaints and grievances in the Medicare End-Stage Renal Disease Program by or on behalf of an individual with kidney failure.

Form – CMS-216-94 "Organ Procurement Organization Provider Histocompatibility Laboratory General Data And Certification Statement"

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms216.pdf
This form is used as the organ procurement organization histocompatibility laboratory general data and certification statement.

This educational product 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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