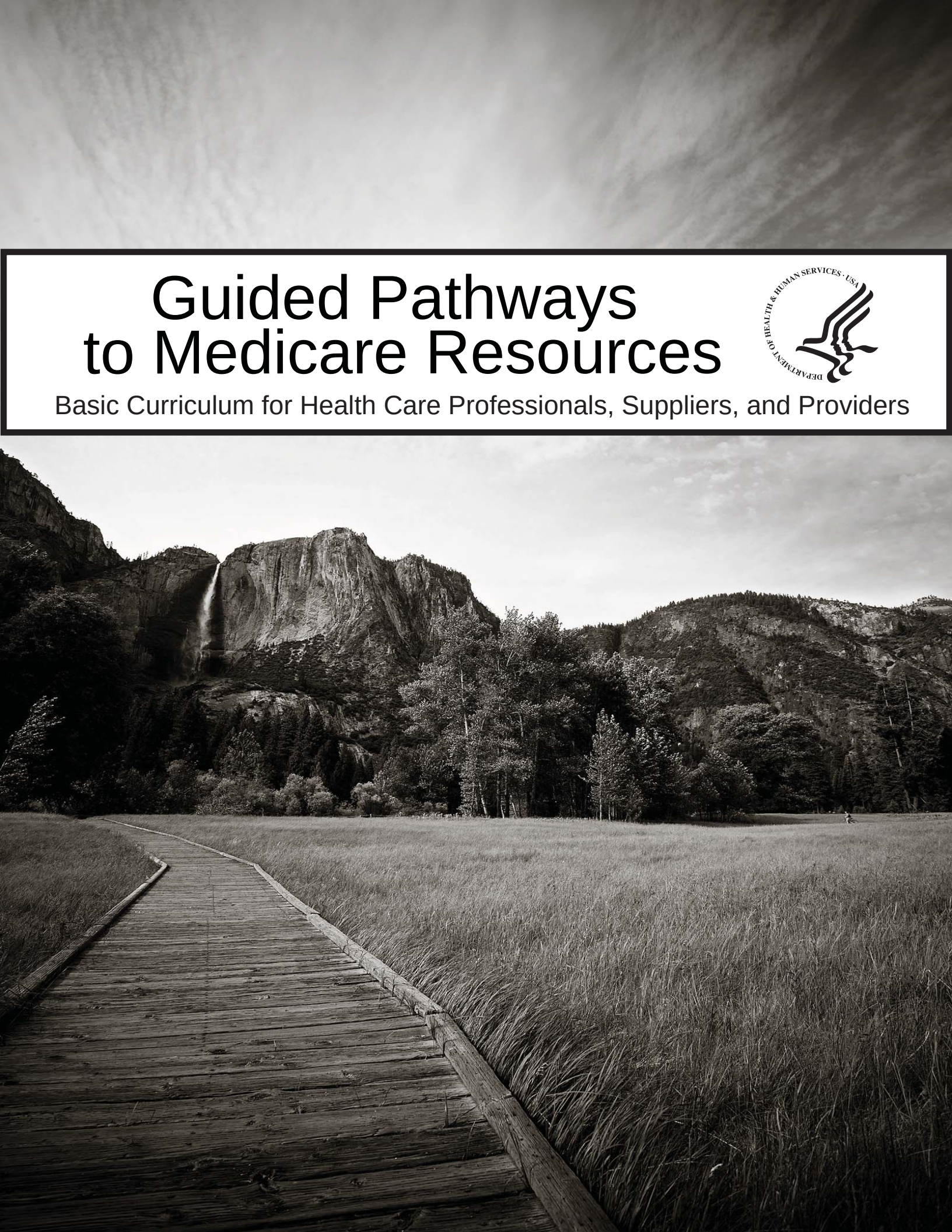
Guided Pathways to Medicare Resources

Basic Curriculum for Health Care Professionals, Suppliers, and Providers



GUIDED PATHWAYS TO MEDICARE RESOURCES
Basic Curriculum for Health Care Professionals, Suppliers, and Providers

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GUIDED PATHWAYS TO MEDICARE RESOURCES
Basic Curriculum for Health Care Professionals, Suppliers, and Providers

INTRODUCTION TO GUIDED PATHWAYS

Welcome to Guided Pathways to Medicare Resources: Basic Curriculum for Health Care Professionals, Suppliers, and Providers. This basic curriculum takes you on a tour of Medicare resources. You are encouraged to travel further down the path of Medicare knowledge by also visiting one or both of the intermediate curricula which take you to more detailed Medicare Fee-for-Service (FFS) policies and requirements.

- Guided Pathways to Medicare Resources: Intermediate Curriculum for Health Care Providers for those providers who enroll using the 855 A form; or
- Guided Pathways to Medicare Resources: Intermediate Curriculum for Health Care Professionals and Suppliers for those providers who enroll using the 855 B, I, or S forms.

We generally anticipate that most learners will meander through these resources and click on only topics of interest to them, instead of proceeding line-by-line.

CENTERS FOR MEDICARE & MEDICAID (CMS) INFORMATION

Navigating the CMS Website

CMS Website
http://www.cms.hhs.gov
The CMS website provides information on numerous Medicare-related topics. Billing, CMS forms, coding, coverage, prevention, and other areas of interest for Medicare providers are covered.

About This Website
http://www.cms.hhs.gov/AboutWebsite/12_Aboutthiswebsite.asp
The CMS website is organized in four levels: top-level subject area, category, section, and page. This web page features information about the design of the website and its features.

Medicare Learning Network (MLN)

Medicare Learning Network (MLN)
http://www.cms.hhs.gov/MLNGenInfo
The MLN is the brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives. The MLN offers a variety of training and educational materials to assist providers in understanding Medicare policy.

MLN Products
http://www.cms.hhs.gov/MLNProducts
MLN products include various educational and instructional materials such as brochures, training guides, videos, fact sheets, and more. Most publications may be downloaded from this web page. Others may be ordered through the MLN Products Catalog or MLN Product Ordering Page which are accessible from this web page.

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles
MLN Matters Articles are designed to help physicians, providers, and suppliers understand new or changed Medicare policy. Articles are prepared in consultation with clinicians, billing experts, and CMS subject matter experts and are tailored in content and language to the specific provider type(s) who are affected by a particular Medicare change. MLN Matters Articles are also distributed via the CMS Mailing List, which may be accessed from this web page.

MLN Web-Based Training (WBT)
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
WBT courses allow providers to view and enroll in online courses. Each course lasts between 60 to 120 minutes. Courses are designed to improve participants' understanding of Medicare, preventive care, payment policy, office management, and more.

MLN Catalog
http://www.cms.hhs.gov/MLNProducts/02_Catalog.asp
The MLN catalog features a listing of MLN products that can be ordered free of charge. Products include brochures, fact sheets, and training guides.

MLN Contractor Contact Information
http://www.cms.hhs.gov/MLNProducts
For a list of contractor contact numbers according to state, click on the Provider Call Center Toll-Free Numbers Directory.

Fast Fact:
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacted numerous contracting reforms. A key aspect of these reforms is that Medicare has begun integrating Fiscal Intermediaries (FIs) and carriers into a single authority, called a Medicare Administrative Contractor (MAC). From October 2004 through October 2011, all existing FI and carrier contracts will be transitioned into MAC contracts, using competitive procedures.

Provider Resources

Open Door Forums
http://www.cms.hhs.gov/opendoorforums
Open Door Forums provide an opportunity for live dialogue between CMS and the provider community at large to understand and find solutions to contemporary program issues. Provider forum participants discuss issues associated with coverage, coding, payment, and more. Visit this web page to view a listing of all forums and to sign up for the Open Door Forum mailing list.

Travel Tip:
To be notified of when the next Open Door Forums are scheduled, please see the Related Links Inside CMS on this web page, and sign up on the mailing list.

CMS Website Wheel
http://www.cms.hhs.gov/MLNProducts/02_Catalog.asp
The Website Wheel is a web page-locating tool designed to help find information on the CMS website by specific topic. This information resource may be ordered from the MLN catalog.

Provider Resource Center
http://www.cms.hhs.gov/center/provider.asp
The Provider Resource Center provides quick access to Medicare Program information. This web page is a one-stop resource focused on the informational needs and interests of Medicare FFS providers, including physicians, other practitioners, and suppliers. Use it to find educational resources, information by provider type, tools, resources, contacts, and to subscribe to the provider listserv.

General Medicare Information

Medicare Coverage Center
http://www.cms.hhs.gov/center/coverage.asp
The Medicare Coverage Center provides a wealth of information on Medicare's coverage process. Essential components covered include the National Coverage Determination (NCD) process, Medicare Coverage Advisory Committee (MCAC) meetings, technology assessments, guidance documents, and background information on the coverage process. In addition, the Medicare Coverage Database features indexes to local and national policy information and supports searches of a compilation of both national and local coverage determinations based on various criteria.

Quarterly Provider Updates
http://www.cms.hhs.gov/quarterlyproviderupdates
Quarterly Provider Updates make it easier for physicians, providers, suppliers, and the general public to understand changes that CMS proposes or makes to the Medicare Program. Visit this site to review quarterly updates for regulations and major policies currently under development during the current quarter, major policies completed or cancelled, and new or revised manual instructions for the CMS Online Manual system. Be sure to also subscribe to the CMS Quarterly Provider Update listserv.

Fast Fact:
CMS publishes this Update at the beginning of each quarter to inform the public about the following:

- Regulations and major policies currently under development during this quarter,
- Regulations and major policies completed or cancelled, and
- New/Revised manual instructions.

CMS regulations establish or modify the way CMS administers its programs. CMS regulations may impact providers or suppliers of services or the individuals enrolled or entitled to benefits under CMS programs.

CMS Online Manual System
http://www.cms.hhs.gov/manuals
The CMS Online Manual System offers operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. Internet-Only Manuals (IOMs) and Paper-Based Manuals are featured.

Understanding the Medicare Learning Network (MLN)
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS064374&intNumPerPage=10
This fact sheet explains the MLN web pages within the CMS website. It provides an overview of the MLN and where to access information and education resources available through the MLN.

INTRODUCTION TO THE MEDICARE PROGRAM

Medicare Program Information

World of Medicare Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course introduces the Medicare Program, including its purpose and history, coverage, CMS and contractor roles, and the claims handling process. Beneficiary-related topics such as eligibility and benefit options are also covered.

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=residents&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061390
This guide offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals.

Front Office and Medicare Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
The patient registration process and front office tasks are vital for successful Medicare claims filing. This course teaches the important steps front office staff should take in gathering patient information for Medicare claims processing. It also explains the importance of obtaining accurate information.

Medicare-Medicaid Relationship Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061407&intNumPerPage=10
This brochure offers an overview of Medicaid and of the relationship between Medicaid and Medicare.

Medicare Modernization Update Web Page
http://www.cms.hhs.gov/MMAUpdate/01_Overview.asp#
This web page contains a summary of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) and its provisions.

Fast Fact:
On December 8, 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. L. 108-173). This landmark legislation provides seniors and individuals with disabilities with a prescription drug benefit, more choices, and better benefits under Medicare.

Medicare General Information, Eligibility, and Entitlement Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=eligibility&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS050111
A general overview of the Medicare Program is provided in this manual, along with responsibilities for Medicare providers and contractors. Medicare covered and non-covered services are listed, as well as important Medicare Program definitions. The manual also covers Part A deductibles and Part B coinsurance information and the importance of physician certification within the Medicare Program.

Medicare History Web Page
http://www.cms.hhs.gov/History
This web page offers a brief history of the inception of the Medicare Program and its changes.

INFORMATION ABOUT BECOMING A MEDICARE PROVIDER

National Provider Identifier (NPI)

National Provider Identifier (NPI) Web Page
http://www.cms.hhs.gov/NationalProvIdentStand
The NPI web page provides an overview of the NPI program, program regulations, NPI application, and NPI implementation guidelines. All providers must obtain an NPI. An NPI must be obtained before an individual can apply to be a Medicare provider.

Fast Fact:
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services (HHS) adopt a standard unique identifier for health care providers called the National Provider Identifier (NPI). The NPI replaces health care provider identifiers that were previously used in standard transactions and eliminates the need to use different identification numbers when conducting HIPAA standard transactions with multiple plans. Providers can apply for an NPI using one of the following methods:

- Visit https://nppes.cms.hhs.gov on the CMS website and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or

With the provider's permission, an Electronic File Interchange Organization (EFIO) can submit the application data.

For the most current information, the CMS website has a dedicated web page on NPI for all health care providers. Visit http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

NPI Application
http://www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp
Visit this web page to download an NPI application.

Provider Enrollment Process

CMS Provider-Supplier Enrollment Web Page
http://www.cms.hhs.gov/MedicareProviderSupEnroll/
The CMS Provider-Supplier Enrollment web page provides Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers. It features brochures, enrollment applications, provider enrollment contacts by state, and web page links to important information.

Medicare Enrollment for Physicians, Non-Physician Practitioners, and Other Health Care Suppliers Fact Sheet
http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/suppliers.pdf
This fact sheet provides information about enrolling in the Medicare Program. It also explains the benefits of participation.

Provider Enrollment Forms Enrollment Applications Web Page
http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp
This web page lists the different types of enrollment applications and offers a link to the CMS Forms page where the applications may be downloaded. Enrollment application submission information is also provided.

Fast Fact:
To make changes to the provider enrollment information on file with a Medicare FFS contractor, providers and suppliers should report changes using the applicable provider enrollment application (CMS-855) for the appropriate provider/supplier type.

Medicare General Information, Eligibility, and Entitlement Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=eligibility&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS050111
A general overview of the Medicare Program is provided in this manual, along with responsibilities for Medicare providers and contractors. Medicare covered and noncovered services are listed, as well as important Medicare Program definitions.

Provider Resource Center
http://www.cms.hhs.gov/center/provider.asp
The Provider Resource Center provides quick access to Medicare Program information. This web page is a one-stop resource focused on the informational needs and interests of Medicare FFS providers, including physicians, other practitioners and suppliers. Use it to find educational resources, information by provider type, tools, resources, contacts, and to subscribe to the provider listserv.

Travel Tip:
The Provider Resource Center offers downloads and links to FFS Medicare Providers including spotlights for providers and a What's New section for the MLN.

MEDICARE REIMBURSEMENT

Beneficiary Notice Initiative (BNI) and Electronic Data Interchange (EDI)

Beneficiary Notice Initiative (BNI) Web Page
http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp
Visit this web page to learn about Medicare beneficiary and provider rights and protections related to financial liability under the FFS Medicare and the Medicare Advantage (MA) Programs. Information is provided regarding Advance Beneficiary Notices (ABNs) and Notices of Exclusion from Medicare Benefits (NEMBs). Links to ABN and NEMB forms by provider type or physician classification are also included, as well as statutory guidance regarding applicable laws related to financial liability protections.

Fast Fact:
Beneficiary Notices Initiative (BNI):
BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections.

Electronic Data Interchange (EDI) Web Page
http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp
This web page provides an overview of EDI, contact numbers for EDI support, and privacy guidelines used to protect sensitive data. It also covers how to enroll in Medicare's EDI program and how to request Medicare to electronically transfer funds for services provided to Medicare beneficiaries.

Travel Tip:
Within the EDI web page, please see pages on specific types of EDI conducted by Medicare for related links and downloads as applicable.

EDI Enrollment
http://www.cms.hhs.gov/ElectronicBillingEDITrans/03_EnrollInEDI.asp
The CMS standard EDI enrollment form must be completed prior to submitting electronic media claims (EMC) or other EDI transactions to Medicare. The agreement must be executed by each provider of health care services, physician, or supplier that intends to submit EMC or use EDI, either directly with Medicare or through a billing service or clearinghouse.

Certificate of Medical Necessity (CMN) Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course offers information about the CMN. It covers the completion, submission, and maintenance of the documentation required to verify the CMN. Topics include items that require a CMN, physician, physician assistant, nurse practitioner, or clinical nurse specialist responsibilities as they relate to the CMN, medical record documentation, sections of a CMN, common CMN errors, and CMN completion resources.

CMN Forms
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp
Use the "Search" feature on the CMS forms web page to access all CMN forms.

Travel Tip:
The CMS Forms web page provides access and/or information for many CMS forms. You may also use the "Search" feature to more quickly locate information for a specific form number or form title.

World of Medicare Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course introduces the Medicare Program, including its purpose and history, coverage types, agency and contractor roles, and the claims handling process. Beneficiary-related topics such as eligibility and benefit options are also covered.

Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and International Classification of Diseases, Clinical Modification (ICD-9-CM)

HCPCS Web Page
http://www.cms.hhs.gov/MedHCPCSGenInfo/
The CMS HCPCS web page offers an overview about the HCPCS and how these codes are used on claims. Find out how to request modification to HCPCS codes, obtain a list of HCPCS codes, and how to submit questions about these codes.

Fast Fact:
The Healthcare Common Procedure Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

American Medical Association Website
http://www.ama-assn.org
Visit the American Medical Association's website to purchase a CPT book or an ICD-9-CM manual.

Diagnosis Coding: Using the ICD-9-CM Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course covers how to select accurate diagnosis codes from the International Classification of Diseases, Clinical Modification (ICD-9-CM) volumes and how to use diagnosis and procedure codes correctly on Medicare claim forms.

Fast Fact: The ICD-9-CM Manual consists of 3 volumes:

Volume 1 Tabular List of Diseases and Injuries
Volume 2 Alphabetic Index of Diseases and Injuries
Volume 3 Tabular List and Alphabetic Index of Procedures

Comprehensive Error Rate Testing (CERT)

Comprehensive Error Rate Testing (CERT) Web Page
http://www.cms.hhs.gov/CERT
This web page provides a brief overview of the CERT program and a link to CERT reports. The CERT program monitors and reports the accuracy of Medicare FFS payments.

MLN Matters Article SE0526
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0526.pdf
This MLN Matters article focuses on the importance of complying with CERT requests for claim documentation.

Medicare Secondary Payer (MSP)

Medicare Secondary Payer and You Web Page
http://www.cms.hhs.gov/MedicareSecondPayerandYou/
Visit the MSP web page for information on MSP laws and the various methods employed by CMS to gather data that may be primary to Medicare. MSP definitions are also featured, along with a delineation of responsibilities for providers, beneficiaries, attorneys, insurers, and employers.

Fast Fact:
The term "Medicare Secondary Payer" is sometimes confused with Medicare supplement. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the *primary payer*. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare Program.

Medicare Secondary Payer Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=secondary&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS019017
This manual is a CMS authoritative reference for MSP issues. It provides background information on the creation of the Medicare MSP program. It also offers billing guidelines on how to appropriately submit MSP claims for payment. The Coordination of Benefits (COB) is explained and the COB contractor's responsibilities are given in detail. Finally, the manual details the process used by Medicare contractors to recover Medicare monies paid inappropriately to providers because of MSP laws.

Coordination of Benefits Contractor Web Page
http://www.cms.hhs.gov/COBGeneralInformation/01_Overview.asp
This web page provides an overview of the Coordination of Benefits Contractor (COBC) role and when providers should call the COBC. It also features hot topics and other important COBC links.

Medicare Remit Easy Print Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1209603&intNumPerPage=10
This brochure provides information about software enabling physicians and suppliers to view and print remittance information.

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=guide&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061410&intNumPerPage=10
This guide is a resource for Medicare physicians, providers, and suppliers to promote a better understanding of the standard Remittance Advice (RA). It contains information on the types of RAs, the purpose of RAs, and how to read an RA.

Reimbursement Methodologies

Medicare Fee Schedule Web Page
http://www.cms.hhs.gov/FeeScheduleGenInfo/
CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies. The Medicare Fee Schedule web page provides fee schedule specifics and links for billing guidelines and reimbursement issues.

Travel Tip: CMS Physician Fee Schedule Lookup Resource
Billers who may be processing claims or claim denials can access the MPFS lookup resource at http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp on the Web. This website is designed to provide information on services covered by the MPFS.

Prospective Payment Systems Web Page
http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/
The Prospective Payment Systems web page provides links for billing guidelines, reimbursement issues, provider-specific data used to develop PPS, and Health Insurance Prospective Payment System (HIPPS) Codes for each PPS that uses it.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912
Chapter 3 of the Medicare Claims Processing Manual contains information on hospital "bad debts", paramedical education program costs, and organ acquisition costs. Read chapters 6 and 10 for reimbursement information on specified drugs for Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs).

Hospital Center Web Page
http://www.cms.hhs.gov/center/hospital.asp
Take a look at the payment listing links on this web page for reimbursement information per provider type.

Practice Administration Center
http://www.cms.hhs.gov/center/practice.asp
To view reimbursement information, select the Medicare Part B Drugs Average Sale Price located under the Medicare FFS Part B Drugs section.

Medicare Provider Reimbursement Manual
http://www.cms.hhs.gov/Manuals/PBM/list.asp
The Medicare Provider Reimbursement Manual (Part 1 and Part 2) offers detailed information about the provider reimbursement process by provider type.

Beneficiary Notice Initiative (BNI) Web Page
http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp
Visit this web page to learn about Medicare beneficiary and provider rights and protections related to financial liability under the FFS Medicare and the Medicare Advantage (MA) Programs. Information is provided regarding Advance Beneficiary Notices (ABN) and Notices of Exclusion from Medicare Benefits (NEMB). Links to ABN and NEMB forms by provider type or physician classification are also included, as well as statutory guidance regarding applicable laws related to financial liability protections.

Fast Fact:
The Notice of Exclusion from Medicare Benefits (NEMBs) is not based on the beneficiary liability protections established by section 1879 of the Social Security Act but may be used to fulfill other notice requirements. NEMBs alert Medicare beneficiaries in advance that Medicare does not cover certain item(s) and service(s) because the item or service do not meet the definition of a benefit, or because the item or service is specifically excluded by law.

Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Bonuses Web Page
http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/01_Overview.asp
This web page offers an overview of the HPSA / PSA program and explains how the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) modified it. It also features a listing of HPSA and PSA areas by zip code. Other helpful links are offered to determine eligibility for participation in the HPSA / PSA program.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=claims&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS018912
Read Chapter 12, Section 90.4.5 to learn more about HPSA and PSA bonuses. This section explains when a Medicare contractor issues these payments and it provides guidelines the contractor uses for issuing them.

Census Bureau Website
http://www.census.gov
The Census Bureau's website offers tools to further research census information. Individuals may access population information and other statistics to assist in determining HPSA / PSA program eligibility.

Financial Institutions Examination Council Website
http://www.ffiec.gov/Geocode/default.aspx
The Financial Institutions Examination Council website offers geocoding information by street address.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Web Page
http://www.cms.hhs.gov/HIPAAGenInfo
The CMS HIPAA web page contains HIPAA regulations and statutes. It also features HIPAA privacy standard and compliance regulations so that providers can ensure their organizations comply.

Fast Fact:
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the HHS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data.

HIPAA Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course provides a general understanding of the history and purpose of HIPAA. Health care claim transactions, information architecture, the Administrative Simplification Compliance Act (ASCA), EDI, and the health care claims cycle are covered.

Evaluation and Management (E & M) Documentation

Evaluation and Management Services Guide
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=guide&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061769&intNumPerPage=10
This guide offers E & M services information to Medicare health care providers that will help improve medical record documentation. It provides background on medical record documentation requirements, key elements of service, history, examination, medical decision making, and documentation of an encounter dominated by counseling and/or coordination of care. Guidelines for residents and teaching physicians are also featured.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=claims&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS018912
Chapter 12 of the Medicare Claims Processing Manual features information on E & M services. This chapter provides information how E & M must comply with the Correct Coding Initiative (CCI) and features examples with specific codes.

Part A Reimbursement Information

Form CMS-1450
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp
Search the forms page for “1450” to pull up the form. The Form CMS-1450 is the standard hardcopy claim form used by Part A providers to bill Medicare when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. Review a copy of the form and become familiar with all of the various sections.

Uniform Billing (UB)-04 (CMS Form-1450) Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course provides detailed information on the CMS Form-1450, or UB-04. By taking it, you will learn how to file Medicare Part A claims accurately and thereby reduce your chances of receiving claim rejections.

CMS Form-1450 Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1198684&intNumPerPage=10
This fact sheet provides information about the CMS Form-1450 including a crosswalk detailing the data elements of the form.

Electronic Health Care Claims Web Page
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp
Providers should normally submit Medicare claims electronically to a Fiscal Intermediary (FI). The computer’s software must meet electronic filing requirements as established by the HIPAA claim standard along with CMS requirements contained in the provider enrollment and certification agreements. This web page offers information on the charges for this service, instructions for submitting claims electronically, standards for electronic

billing, and the electronic flat file format used for electronic claims. Part A flat file, edits, and a companion document are also available for download.

National Correct Coding Initiative (CCI) Web Page
http://www.cms.hhs.gov/NationalCorrectCodInitEd/
CMS developed the CCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. This web page provides an overview of the CCI, as well as links to CCI edits for both physicians and hospital outpatient PPS.

Fast Fact:
CMS developed the CCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Outpatient Code Editor (OCE) Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course is useful in understanding the OCE utilized under the Outpatient Prospective Payment System (OPPS) and other payment systems. It addresses the OCE in the Fiscal Intermediary Standard System (FISS).

Cost Reporting – Provider Reimbursement Part A Manual – Part 2
http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021935
A cost report is used by Medicare providers to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries. This manual features information about cost reports regulations, timeliness standards for submitting one, interim payments, guidelines for new providers versus established providers, and detailed instructions for completing a cost report.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=claims%20processing&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS018912
This manual contains authoritative guidelines from CMS on the Medicare billing process for Part A. Chapter 1 describes Medicare billing policy for Medicare FFS claims. It gives an overview of Medicare and discusses claim jurisdiction. Chapter 2 contains information on insurance and entitlement verification. Chapters 3 and 4 discuss billing guidelines for inpatient and outpatient hospital services. Chapter 5 discusses billing requirements for rehabilitation clinics. Chapters 6 and 7 discuss billing guidelines for inpatient and outpatient skilled nursing facility services. Chapter 10 discusses billing requirements for home health. Chapter 11 discusses billing requirements for Hospice.

Part B Reimbursement Information

Form CMS-1500
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp
Search the forms page for “1500” to pull up the form. The Form CMS-1500 is the standard hardcopy claim form used by non-institutional providers or suppliers to bill Medicare when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. Review a copy of the form and become familiar with all of the various sections.

Fast Fact:
The CMS Form-1500 (08/05) fields clearly identify where NPIs are to be entered for billing and rendering providers.

CMS Form-1500 Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This is a 60-minute course that provides detailed information on the CMS Form-1500. After completing the course, learners should know how to file Medicare Part B claims accurately and thereby reduce your chances of receiving claim rejections.

CMS Form-1500 Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1209453&intNumPerPage=10
This fact sheet provides information about the CMS Form-1500 including exceptions to mandatory electronic claim submission and tips for submitting error-free claims.

Electronic Health Care Claims Web Page
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp
Physicians and suppliers should submit Medicare claims electronically to a Medicare Carrier, Durable Medical Equipment Medicare Administrative Contractor (DME MAC) from the doctor's or supplier's office. This web page offers information on the charges for this service, instructions for submitting claims electronically, standards for electronic billing, and the electronic flat file format used for electronic claims. Part B flat file and companion documents may also be downloaded.

Fast Fact:
How to Submit Medicare 1500 Claims: Claims may be electronically submitted to a Medicare MAC, Carrier, DME MAC from a provider's office using a computer with software that meets electronic filing requirements as established by the HIPAA claim standard and by meeting CMS requirements.

National Correct Coding Initiative (NCCI) Web Page
http://www.cms.hhs.gov/NationalCorrectCodInitEd/
This web page shows NCCI edits for physicians. To view codes for a particular service type, click the appropriate link in the list.

Reference Guide for Medicare Physician and Supplier Billers
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Reference&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS063048&intNumPerPage=10
This guide contains a variety of information to help claims processors submit accurate and timely Medicare claims. It focuses on providing claim information and billing procedures for FFS physicians and suppliers to help them submit Medicare Part B claims accurately. It also discuss HIPAA, Medicare enrollment, and Medigap.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912
This manual contains authoritative guidelines from CMS on the Medicare billing process for Part B. Chapter 1 describes Medicare billing policy for Medicare FFS claims. It gives an overview of Medicare, discusses claim jurisdiction, and Medicare assignment. Chapter 12 provides claims processing instructions for physician and non-physician practitioner services. Chapter 13 describes billing and payment for radiology services. Chapter 16 outlines billing and payment under the laboratory fee schedule. Chapter 17 provides a

description of billing and payment for drugs. Chapter 26 includes information about claims submission.

PROTECTING THE MEDICARE TRUST FUND

Fraud and Abuse

Medicare Fraud and Abuse Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1186395&intNumPerPage=10
This resource reference directs you to a number of sources of information pertaining to Medicare fraud and abuse and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse.

Protecting Your Practice brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Practice&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061430&intNumPerPage=10
This brochure highlights some of the steps Medicare physicians and other health care professionals can take to protect their practices from inappropriate Medicare business interactions.

Chapter 6 of the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals, entitled Protecting the Medicare Trust Fund
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Physician&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1184005&intNumPerPage=10
This guide offers general information about the Medicare Program. Chapter 6 focuses on fraud and abuse information.

Section 5 of the Reference Guide for Medicare Institutional Providers Who Submit Part B Claims entitled Protecting Medicare From Fraud and Abuse
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=guide&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS063048&intNumPerPage=10
This guide is focused on providing information and procedures for institutional entities that provide Part B services in additional to, or instead of, Part A services. Section 5 covers fraud and abuse information.

Fraud and Abuse – Medicare Program Integrity Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019033
The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste, and abuse.

Anti-Kickback Statute
http://oig.hhs.gov/fraud.html
Information on this OIG web page covers anti-kickback and safe harbor regulations.

Fast Fact:
The Anti-Kickback Statute, set forth at § 1128B of the Social Security Act, (42 U.S.C. § 1320a-7b), makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.

Exceptions to the prohibition on self referrals CFR 411.355-357
http://www.gpoaccess.gov/cfr/index.html
Commonly referred to as the "Stark Law," this statute prohibits physicians from referring Medicare patients 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. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral.

Physician Self-Referral Prohibition Statute
http://www.cms.hhs.gov/PhysicianSelfReferral
The physician self-referral law is set forth in section 1877 of the Social Security Act. The law prohibits physicians from referring Medicare patients for certain 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. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral.

OIG Fraud Prevention and Detection
http://www.oig.hhs.gov/fraud.html and/or OIG Website http://www.oig.hhs.gov
The HHS Office of Inspector General's (OIG) website offers a wealth of information regarding fraud and abuse prevention, detection, and reporting.

Travel Tip:
If you have identified billing practices that cause you to suspect potential fraud or abuse, you may call the OIG's National Hotline to report the activity.
Contacting the HHS OIG Hotline:
By Phone: 1-800-HHS-TIPS (1-800-447-8477)
By Fax: 1-800-223-8164
By E-Mail: HHSTips@oig.hhs.gov
By TTY: 1-800-377-4950
By Mail:
Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
330 Independence Ave, SW
Washington, DC 20201

OIG Advisory Opinions
http://oig.hhs.gov/fraud/advisoryopinions.html
In certain situations, upon formal request, the HHS OIG may issue an advisory opinion with respect to the anti-kickback statute or OIG's other fraud and abuse authorities, while CMS may issue an advisory opinion with respect to the physician self-referral prohibition. Advisory opinions are legal opinions issued to one or more requesting parties about the application to a party's existing or proposed business arrangements of either the fraud and abuse provisions within the OIG's scope of authority or the physician self-referral prohibition within CMS' scope of authority.

CMS Advisory Opinions
http://www.cms.hhs.gov/PhysicianSelfReferral/07_advisory_opinions.asp
Section 1877(g)(6) of the Social Security Act (the Act) requires that the Centers for Medicare and Medicaid Services issue certain written advisory opinions. These opinions must discuss whether a physician's referrals relating to certain designated health services (other than clinical laboratory services) are prohibited under the Medicare Program by section 1877 of the Act.

OIG Exclusions
http://oig.hhs.gov/fraud/exclusions.html and the OIG List of Excluded Individuals/Entities (LEIE) http://epls.arnet.gov
For many years the Congress of the United States has worked diligently to protect the health and welfare of the nation's elderly and poor by implementing legislation to prevent certain individuals and businesses from participating in Federally-funded health care programs. The OIG, under this Congressional mandate, established a program to exclude individuals and entities affected by these various legal authorities, contained in sections 1128 and 1156 of the Social Security Act, and maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities.

Coverage Decisions/Determinations

Medicare Coverage Determination Process
http://www.cms.hhs.gov/DeterminationProcess/
Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). This page focuses on coverage information.

Medicare Program Integrity Manual (Pub. 100-8)
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019033
The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste, and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.

Fast Fact:
FIs, carriers, Program Safeguard Contractors (PSC), and Medicare Administrative Contractors (MACs) are Medicare contractors that develop and/or adopt Local Coverage Determinations (LCDs). Medicare contractors develop LCDs when there is no National Coverage Determination (NCD) or when there is a need to further define an NCD. The guidelines for LCD development are provided in Chapter 13 of the Medicare Program Integrity Manual.

National Coverage Determinations (NCDs)
http://www.cms.hhs.gov/center/coverage.asp
NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under §1862(a)(1) of the Act or other applicable provisions of the Act.

Local Coverage Determinations (LCDs) website
http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp
A LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a Fiscal Intermediary or carrier whether to cover a particular service on an Intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

APPEALS

The Medicare Appeals Process

Five Levels to Protect Physicians and Other Suppliers Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1185028&intNumPerPage=10
Topics covered include appealing Medicare decisions, the five levels of the Appeals process, requesting a review in writing, hearings, Administrative Law Judge, Judicial Review, and Departmental Appeals Board review. This brochure is available from the MLN catalog.

Appeal Forms

Form CMS-1696 - Appointment of Representative
http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf
This form is used by a beneficiary to appoint an individual to act as his or her representative in connection with a Medicare claim. Review this form to learn more about its requirements.

Form CMS-20027 – Medicare Redetermination Request Form
http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf
An appellant party that wants to request a redetermination after a claim is denied by a Medicare contractor may do so by completing this form. Review this form to learn more about what is required to submit a redetermination along with timeframes for submitting it.

Form CMS-20033 – Medicare Reconsideration Request Form
http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf
An appellant party dissatisfied with the redetermination decision may request a reconsideration by a Qualified Independent Contractor (QIC). It can do this by completing Form CMS-20033. Review this form to learn more about what is required to submit a reconsideration along with timeframes for submitting it.

Form CMS-20034A/B – Request for Medicare Hearing By An Administrative Law Judge
http://www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf
If an appellant party is dissatisfied with the reconsideration decision (or hearing officer decision) or if the adjudication period for the Qualified Independent Contractor (QIC) to complete its consideration has elapsed, he or she can request a hearing before an Administrative Law Judge (ALJ) with the Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals. It can do this by completing Form CMS-20034A/B. Review this form to learn more about what is required to request an ALJ hearing along with timeframes for requesting it.

Form DAB-101 – Request for Review of Administrative Law Judge (ALJ) Medicare Decision / Dismissal
http://www.hhs.gov/dab/DAB101.pdf
The Form DAB-101 is a form used to appeal a decision to the Medicare Appeals Council (MAC) Review. The appellant or any other party to the ALJ hearing may request a MAC review of the ALJ's decision or dismissal. Download this form and review it along with the requirements for submitting the form.

Travel Tip: Forms
CMS is a Federal agency within the U.S. Department of Health and Human Services. Many CMS program related forms are available in Portable Document Format (PDF). Hard copy forms may be available from Intermediaries, carriers, State Agencies, local Social Security Offices or End Stage Renal Disease Networks that service your State.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10
Chapter 29 of the Medicare Claims Processing Manual contains authoritative guidelines from CMS on the Medicare appeals process. It discusses in detail the five step appeals process and also delineates the roles of Medicare contractors, Administrative Law Judges (ALJ), the Departmental Appeals Board (DAB), and the U.S. District Court. Finally, it lists the requirements for appointing a representative to argument an appeal on the behalf of a beneficiary and a provider.

FFS Appeals Web Page
http://www.cms.hhs.gov/OrgMedFFSAppeals/
This web page provides an overview of the five levels of the Medicare Part A and B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries. Links are also provided to additional information about the appeals process.

MLN Matters Article MM4152
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4152.pdf
The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). By reading this article, you will learn about the changes and its impacts on the Medicare appeals process.

OVERPAYMENTS

Travel Tip: Overpayments
The physician or other supplier has the right to appeal the decision if he or she disagrees with the overpayment. Effective with Joint Signature Memorandum #255, dated June 3, 2004, recoupment will cease as a result of a demand letter if:
(a) the overpayment is determined on or after October 29, 2003, and
(b) a valid first level appeal has been received.

Overpayment Publications

What Physicians and Other Suppliers Need to Know About Medicare Overpayments Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Overpayments&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061392&intNumPerPage=10
This tri-fold brochure provides a general overview of the overpayment process for Medicare Part B providers. It includes a working definition of an overpayment, responsibilities when one occurs, and the interest requirements imposed on overpayments.

Manual Sections on Overpayments

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10
Search for overpayments to find specific information.

Medicare Financial Management Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019018
Read Chapter 3 of the Medicare Financial Management Manual to learn more about overpayments. Topics covered include how overpayments are determined by a FI or carrier, as well as how overpayments are recovered (i.e. cost reports, accounts receivable, interim rate adjustments, etc.). Examples are also provided.

MEDICARE SERVICES

Kidney Dialysis and Kidney Transplant Services

Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=guide&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061406&intNumPerPage=10
This guide explains how Medicare helps pay for kidney dialysis and kidney transplant services in the Original Medicare Plan. It also covers how patients get Medicare for kidney failure and how Medicare helps to pay for kidney dialysis and kidney transplants.

Medicare Benefit Policy Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673&intNumPerPage=10
Read Chapter 11, Section 10 in the Medicare Benefit Policy Manual to learn more about kidney dialysis. Information is featured about dialysis and all of its various forms (Hemodialysis, Peritoneal dialysis, etc.) including the equipment, supplies, and maintenance used in treatment of kidney disease. Methods of treatment are also covered.

Creating AV Fistulas in All Eligible Hemodialysis Patients
http://cme.ouhsc.edu/5E016webtropages.htm
Vascular access is required for patients receiving hemodialysis therapy for renal failure. The purpose of this presentation is to educate any physician who provides or directs vascular access placement for hemodialysis patients.

Long Term Care Hospital Prospective Payment System (LTCH PPS)

LTCH PPS High Cost Outlier Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061400&intNumPerPage=10
This fact sheet provides information about the outlier portion of the LTCH PPS. It defines an outlier, provides a case example, explains a calculation and gives Internet references for further research.

LTCH PPS Interrupted Stay Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061401&intNumPerPage=10
This fact sheet provides information about the "Interrupted Stay" portion of the LTCH PPS. It defines an Interrupted Stay, provides several examples, discusses how days are counted during a stay that is interrupted, and gives Internet references for further research.

LTCH PPS News Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061403&intNumPerPage=10
This fact sheet highlights significant policy changes that were adopted for the LTCH PPS according to the May 11, 2007 LTCH PPS and August 22, 2007 Final Rules. It also provides background information on the changes along with a definition of LTCH diagnosis-related groups (DRGs) along with examples and features helpful resource links regarding these changes.

LTCH PPS Short Stay Outlier Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=fact%20sheet&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061402&intNumPerPage=10
This fact sheet provides information on the short stay outlier portion of the Long Term Care Hospital Prospective Payment System (LTCH PPS). It defines a short stay outlier, provides a case example, explains a calculation, and gives Internet references for further research.

LTCH PPS web page
http://www.cms.hhs.gov/LongTermCareHospitalPPS/
This is a one-stop resource web page focused on the informational needs and interests of Long Term Care Hospitals. It provides an overview of the program, has links to various training materials and fact sheets, and is a storehouse for Long Term Care Hospital Prospective Payment System (LTCH PPS) regulations.

Fast Fact:
LTCHs treat patients with multi-comorbidities requiring long-stay hospital-level care. To be designated as an LTCH, Medicare requires that a hospital typically demonstrates that on average, it has an average length of stay for its Medicare patients of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for LTCHs. The LTCH PPS replaced the previous cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvements and Protection Act of 2000 (BIPA).

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10
Read Chapter 3, Section 150 in the Medicare Claims Processing Manual to learn how to bill for LTCH services. Payment policies, coverage requirements, provider certification requirements, and much more are covered in this chapter.

Preventive Services Information

Preventive Services Educational Products Web page
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
The MLN resources listed on this web page give Medicare FFS health care professionals information on coverage, coding, billing, reimbursement, and claim filing procedures for the following Medicare-covered preventive services and screenings (subject to certain eligibility and other limitations):

- Abdominal Aortic Aneurysm Screening
- Adult Immunizations
- Bone Mass Measurements
- Cancer Screenings
- Cardiovascular Screening
- Diabetes Screening
- Diabetes Supplies
- Diabetes Self-Management Training
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)
- Glaucoma Screening
- Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling

In addition to the preventive services educational resources listed on this web page, CMS has also created a prevention website that provides general information about the preventive benefits listed above. You may visit the CMS Prevention website by clicking on the Medicare tab at the top of this page. Once on the CMS Medicare page, scroll down to the Prevention section.

Preventive Services Educational Products Listing
http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf
The educational resources listed on this web page are designed to promote and increase national awareness of the preventive benefits covered by Medicare, provide information that will help health care professionals encourage patient utilization of benefits that they may be eligible for and give information to health care professionals that will help them to file claims effectively.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=guide&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061419&intNumPerPage=10
This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing, and reimbursement. It also discusses the expansion of Medicare's initiated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Quick Reference Information: Medicare Preventive Services
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=quick&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061411&intNumPerPage=10
This two-sided job aid gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance, and deductible information for each benefit.

CMS Adult Immunizations Web Page
http://www.cms.hhs.gov/AdultImmunizations
This adult immunization page provides information and resources related to the coverage, billing, delivery, and promotion of influenza, pneumococcal, and hepatitis B vaccinations.

Influenza (Flu) Season Educational Products and Resources
http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf
All of the seasonal flu resources can be found here.

Adult Immunizations Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061413&intNumPerPage=10
This two-sided, tri-fold brochure provides a basic overview of Medicare's Influenza Vaccine, Pneumococcal Polysaccharide Vaccine (PPV), and Hepatitis B Vaccine benefits. It also discusses risk factors, coverage information, and provides useful resources and web links.

Quick Reference Information: Medicare Immunization Billing
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=quick&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1185622&intNumPerPage=10
This two-sided laminated reference chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration.

Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This course is provided by the Centers for Disease Control and Prevention (CDC). It will help you better understand the importance of adult immunizations and identify ways to increase the immunization rates in your health care community.

Bone Mass Measurements Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061416&intNumPerPage=10
This two-sided tri-fold brochure provides a basic overview of Medicare's bone mass measurements (bone density studies) benefit. It also discusses risk factors, coverage information, and provides useful resources and web links.

Cancer Screenings Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061415&intNumPerPage=10
This two-sided tri-fold brochure provides a basic overview of Medicare's mammography screening, screening Pap test, pelvic screening examination, colorectal cancer screening, and prostate cancer screening benefits. It also discusses risk factors, coverage information, and provides useful resources and web links.

Expanded Benefits Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061418&intNumPerPage=10
This tri-fold brochure provides a basic overview of Medicare's three new preventive benefits: the Initial Preventive Physical Examination (IPPE), cardiovascular screening blood tests, and diabetes screening tests. It also discusses risk factors, coverage information, and provides useful resources and web links.

Glaucoma Screening Brochure
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=brochure&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061414&intNumPerPage=10
This tri-fold brochure provides a basic overview of Medicare's glaucoma screening benefit. It also discusses risk factors, coverage information, and provides useful resources and web links.

CMS Glaucoma Web Page
http://www.cms.hhs.gov/GlaucomaScreening/
This web page discusses Medicare’s coverage of glaucoma screening for people at high risk for the disease. It also provides information and resources for health care professionals.

Medline Health/Glaucoma Web Page
http://www.nlm.nih.gov/medlineplus/glaucoma.html
This web page from the National Institutes of Health lists a variety of resources related to glaucoma.

Medicare Preventive Services Series: Part 2 Women’s Health Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
The goal of this course is to promote wellness, increase the utilization of routine screening for female beneficiaries, and help providers build their practices by promoting the use of preventive services covered by Medicare.

Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training
http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp
This web-based training course provides information about Medicare’s coverage for the three new services added to the Medicare Program in 2005, as a result of the Medicare Modernization Act of 2003 (MMA): initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), diabetes, and cardiovascular disease screenings. The course also includes information on diabetes self management training, medical nutrition therapy, and other diabetes supplies, colorectal, prostate, and glaucoma screenings, and bone mass measurements.

Fast Fact:
A physician or qualified non-physician practitioner (NPP), in various provider settings, may bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Social Security Act, if provided during the Initial Preventive Physical Exam.

Medicare Benefit Policy Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673
Chapter 15 of the Medicare Benefit Policy Manual gives an overview of covered preventive and screening services and provides information on conditions of coverage, frequency, and other special billing instructions.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912
Chapter 18 of this manual contains authoritative guidelines from CMS on Medicare's many preventive services. Topics covered include coverage and payment policies, billing requirements for flu vaccines, pneumococcal vaccines, and Hepatitis B vaccines. Various screening tests such as mammographies, pap smears, prostate screenings, diabetes screenings, colorectal screenings, and glaucoma screenings are also included.

Rural Health Services

Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061395&intNumPerPage=10
The guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005.

Rural Health Clinic Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061823&intNumPerPage=10
This fact sheet provides an overview of rural health clinic services, designations, and payments. It also features a listing of helpful rural health websites.

Rural Referral Center Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061824&intNumPerPage=10
This fact sheet provides an overview of the Rural Referral Center (RRC) program requirements, as well as a listing of helpful rural health websites.

Medicare Disproportionate Share Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061825&intNumPerPage=10
This fact sheet covers methods to qualify for a Medicare disproportionate share hospital adjustment, as well as features Medicare disproportionate share hospital payment adjustment formulas.

Critical Access Hospital Program Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061826&intNumPerPage=10
This fact sheet gives an overview of important factors for CAHs including CAH designation requirements, CAH payments, and HPSA and PSA bonus payments.

Federally Qualified Health Center Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061827&intNumPerPage=10
This fact sheet provides an overview of FQHC designation requirements, covered services, preventive primary services that are not covered, and FQHC payments.

Fast Fact:
The FQHC benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs an all-inclusive per visit.

Sole Community Hospital Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061828&intNumPerPage=10
This fact sheet defines a Sole Community Hospital and offers payment information. It also features a listing of helpful rural health websites.

Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Rural&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1183644&intNumPerPage=10
This guide includes a brief history of the RHC and FQHC programs, an overview of the theory of cost-based reimbursement, and a description of the differences in eligibility criteria, programmatic requirements, and covered services.

Provider Specific Web Pages

Travel Tip:
An electronic mailing list service is offered for those interested in receiving news from CMS. This service is optional. Visit http://www.cms.hhs.gov/apps/mailinglists/default.asp?audience=3 to subscribe or unsubscribe from any CMS mailing list.

Critical Access Hospital Web Page
http://www.cms.hhs.gov/CertificationandComplianc/04_CAHs.asp
This web page provides basic information about being certified as a Medicare and/or Medicaid CAH provider and includes links to applicable laws, regulations, and compliance information.

Federally Qualified Health Center Web Page
http://www.cms.hhs.gov/center/fqhc.asp
This web page provides helpful links about billing and payment, education, and CMS manuals and transmittals.

Rural Health Clinic Web Page
http://www.cms.hhs.gov/CertificationandComplianc/18_RHCs.asp
This web page provides basic information about being certified as a Medicare and/or Medicaid RHC provider and includes links to applicable laws, regulations, and compliance information.

Medicare Benefit Policy Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673
Chapter 13 of the Medicare Benefit Policy Manual features information on RHC and FQHC services.

Medicare Claims Processing Manual
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912
Chapter 9 of the Medicare Claims Processing Manual describes the differences between RHCs and FQHCs, methods of Medicare payment for their services, billing requirements, and other important information.

Clinical Laboratories

Clinical Laboratory Improvement Amendments (CLIA) Brochures
http://www.cms.hhs.gov/CLIA/05_CLIA_Brochures.asp
CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the CLIA program. Topics covered in these brochures include an overview of CLIA, test methods categorized, enrollment in the CLIA program, types of certificates, certificate compliance, performance measures, and certificate of accreditation.

CLIA Web Page
http://www.cms.hhs.gov/CLIA/01_Overview.asp
The objective of the CLIA program is to ensure quality laboratory testing. The CLIA web page on the CMS website provides an overview of the program along with helpful resources and web links to educate laboratories and providers.

Fast Fact:
CLIA established quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health.

Centers for Disease Control and Prevention (CDC) Website
http://www.phppo.cdc.gov/clia/default.aspx
The CDC has the responsibility for test categorization under CLIA. The CDC website features the most current version of the CLIA regulations Part 493, including all changes through 1/24/03. This website may also be used to access a chronological list containing online copies of the CLIA regulations and related Federal Register publications.

Government Printing Office (GPO) Website
http://www.gpoaccess.gov/cfr/index.html
Use the GPO website search feature to locate CLIA-specific regulations in the Code of Federal Regulations (CFR).

Clinical Laboratory Fee Schedule Fact Sheet
http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=Clinical&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1209563&intNumPerPage=10
This fact sheet provides general information about the Clinical Laboratory Fee Schedule, coverage of clinical laboratory services, and how payment rates are set.

OTHER AVAILABLE MEDICARE RESOURCES FOR PROVIDERS

Medicare.gov
http://www.Medicare.gov
Medicare.gov is the official U.S. government website for people with Medicare. The site features information on plan choices, the Medicare prescription drug benefit, billing, appeals, provider information, frequently asked questions, mailing lists, and more. It also has a search tool to assist in locating information.

Social Security Administration (SSA)
http://www.socialsecurity.gov/
This official website of the SSA features information on Medicare, retirement, and other items of interest to people with Medicare.

GPO Federal Register (FR) Web Page
http://www.gpoaccess.gov/fr/index.html
Use this page to browse the FR or access general information about the FR.

Workgroup for Electronic Data Interchange (WEDI) Website
http://www.wedi.org/
The WEDI is dedicated to improving health care through electronic commerce. The WEDI website features a what's new section, upcoming events, and HIPAA information.