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

Medicare Learning Network®

Official Information Health Care Professionals Can Trust

Basic Medicare Information for Providers and Suppliers

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

When "you" is used in this publication, we are referring to Medicare Fee-For-Service (FFS) health care providers.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION TO THE MEDICARE PROGRAM

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

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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

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

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

CMS awards contracts to MACs, who perform claims processing and related administrative functions, and include:

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

THE MEDICARE PROGRAM

In 1965, Title XVIII of the Social Security Act (the Act) established the Medicare and Medicaid Programs. The Medicare Program is the largest health insurance program in the U.S., with more than 50 million enrollees being entitled to benefits. Beginning in 1966, individuals age 65 years and older were able to enroll in Original Medicare. Original Medicare, also known as FFS Medicare, consists of:

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

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

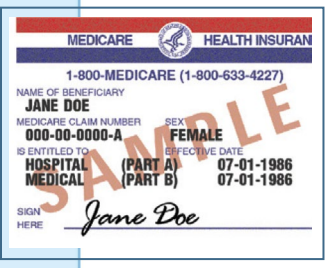
FFS Medicare was expanded in 1973 to include:

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

Two parts were added to the Medicare Program in 1997 and 2006, respectively:

- Part C, MA (first known as Medicare+Choice); and
- Part D, the Prescription Drug Benefit.

Additional information about the four parts of the Medicare Program is provided on pages 3 – 8.



Health Insurance Cards

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

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

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

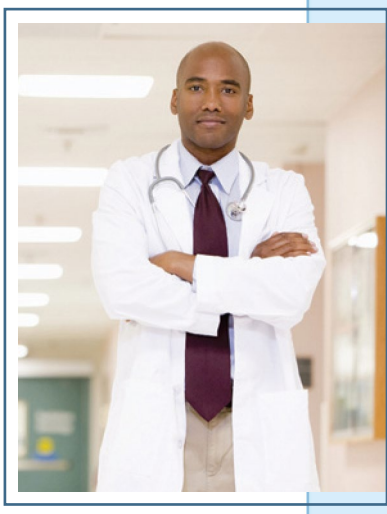
The HIC number on the health insurance card issued by CMS has an alpha or alphanumeric suffix and the Social Security Number (SSN), which is usually either the SSN of the insured or the spouse of the insured (depending on whose earnings eligibility is based). The HIC number on the health insurance card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

Part A – Hospital Insurance

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

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

Eligibility Requirements



To be eligible for premium-free Part A, an individual must first be insured based on his or her own earnings or the earnings of a spouse, parent, or child. To be insured, a worker must have a specified number of quarters of coverage (QC). The exact number of required quarters is dependent on whether he or she is filing for Part A on the basis of age, disability, or ESRD. QCs are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the individual's working years. Most individuals pay the full FICA tax so that the QCs they earn can be used to insure them for both monthly Social Security benefits and Part A. Certain Federal, State, and local government employees pay only the Part A portion of the FICA tax. The QCs these employees earn can be used only to insure them for Part A and may not be used to insure them for monthly Social Security benefits.

Individuals Age 65 Years or Older

To be eligible for premium-free Part A on the basis of age, an individual must be age 65 years or older and either eligible for monthly Social Security or Railroad Retirement cash benefits or would be eligible for such benefits if the worker's QCs from government employment were regular Social Security QCs. Part A for the aged individual begins with the month in which age 65 years is attained, provided he or she files an application for Part A or for cash benefits. The application for Part A must be filed within 6 months of the month in which age 65 years is attained. If the application is filed later than that, Part A entitlement can be retroactive for only 6 months.

For Medicare purposes, an individual attains age 65 years the day before his or her actual 65th birthday, and Part A is effective on the first day of the month upon attainment of age 65 years. For an individual whose 65th birthday is on the first day of the month, Part A is effective on the first day of the month preceding his or her birth month. For example, if an individual's birthday is on December 1, Part A is effective on November 1 because for Medicare purposes, he or she attained age 65 years on November 30. An individual who continues to work beyond age 65 years may elect to file an application for Part A only. Part A entitlement generally does not end until the death of the individual.

A second group of aged individuals who are eligible for Part A are age 65 years or older and are not insured but elect to purchase Part A coverage by filing an application at a Social Security Administration (SSA) office. Because a monthly premium is required, this coverage is called premium Part A. The individual must be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the 5-year period immediately preceding the month the application is filed. Individuals who want premium Part A can only file for coverage during a prescribed enrollment period and must also enroll or already be enrolled in Part B.

Individuals Under Age 65 Years with Certain Disabilities

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

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

Individuals with End-Stage Renal Disease (ESRD)

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

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

Part A coverage begins:

- The third month after the month in which a regular course of dialysis begins;
- The first month self-dialysis training begins (if training begins during the first 3 months of regular dialysis);

- The month of kidney transplant; or
- Two months prior to the month of transplant if the individual was hospitalized during those earlier months in preparation for the transplant.

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

Part B – Medical Insurance

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

- Medically necessary services furnished by physicians in a variety of medical settings, including but not limited to:
  - The physician's office;
  - An inpatient or outpatient hospital setting;
  - Ambulatory Surgical Centers; and
  - ESRD facilities;
- Many preventive services;
- Home health care for individuals who do not have Part A;
- Ambulance services;
- Clinical laboratory and diagnostic services;
- Surgical supplies;
- Durable medical equipment, prosthetics, orthotics, and supplies;
- Hospital outpatient services; and
- Services furnished by practitioners with limited licensing such as:
  - Audiologists;
  - Certified nurse-midwives;
  - Certified registered nurse anesthetists;
  - Clinical nurse specialists;
  - Clinical psychologists;
  - Clinical social workers;
  - Independently practicing occupational therapists;
  - Independently practicing physical therapists;
  - Independently practicing speech-language pathologists;
  - Nurse practitioners; and
  - Physician assistants.

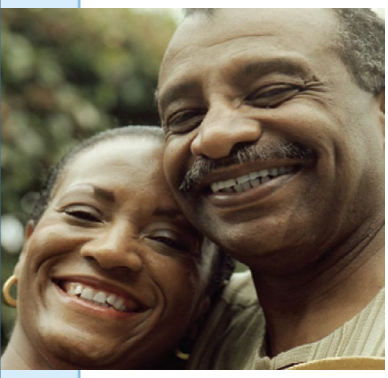
Eligibility Requirements

All individuals who are eligible for premium-free Part A are eligible to enroll in Part B. Because Part B is a voluntary program that requires the payment of a monthly premium, those individuals who do not want coverage may refuse enrollment. An individual age 65 years or older who is not eligible for premium-free Part A must be a U.S. resident and

either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the 5-year period immediately preceding the month the Part B enrollment application is filed. An individual who refused Part B and those whose Part B coverage terminated may enroll or re-enroll in Part B only during prescribed enrollment periods.

Part A and Part B Enrollment Periods

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



- The Initial Enrollment Period (IEP) begins with the first day of the third month before the month premium Part A or Part B eligibility requirements are first met and ends 7 months later (for example, the IEP for the aged begins 3 months before the individual attains age 65 years and ends the third month after the month age 65 years is attained);
- The General Enrollment Period takes place from January 1 through March 31 of each year. Premium Part A and Part B coverage will be effective on July 1;
- The Special Enrollment Period (SEP) for the working aged and working disabled is when an individual may enroll who did not enroll in premium Part A or Part B when first eligible because he or she was covered under a Group Health Plan (GHP) based on his or her own or a spouse's current employment (or the current employment of a family member, if disabled). The individual can enroll at any time while covered under the GHP based on current employment or during the 8-month period that begins the month after the employment ends or the GHP coverage ends, whichever occurs first. An individual with ESRD is not eligible to enroll during this SEP;
- The SEP for international volunteers is when an individual may enroll who did not enroll in premium Part A or Part B when first eligible because he or she was performing volunteer service outside the U.S. on behalf of a tax-exempt organization and had health insurance that provided coverage for the duration of the volunteer service. The individual can enroll during the 6-month period that begins the earlier of the month he or she is no longer performing volunteer service outside the U.S., the month the organization no longer has tax exempt status, or the month the individual no longer has health insurance that provides coverage outside the U.S.; and
- The Transfer Enrollment Period is when an individual who is age 65 years or older, entitled to Part B, and enrolled in a MA Plan may enroll in premium Part A. The individual can enroll during any month in which he or she is enrolled in the MA Plan or during any of the 8 consecutive months following the last month he or she was enrolled in the MA Plan.

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

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

Part C – Medicare Advantage (MA)

Medicare Part C, or MA, is another health plan choice available to beneficiaries. MA is a program run by Medicare-approved private insurance companies. Most MA organizations arrange for or directly provide health care items or services to the beneficiary who:

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

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

When you furnish items or services to a Medicare beneficiary who is enrolled in a MA Plan and you do not have a contract with the MA Plan to furnish the items or services, you should bill the MA Plan. Prior to furnishing items or services to a MA Plan enrollee under these circumstances, you should notify the beneficiary that he or she may be responsible for all related charges, unless such items or services are emergency or urgently needed or he or she is enrolled in a Private Fee-For-Service (PFFS) or Preferred Provider Organization (PPO) type of MA Plan.

Individuals enrolled in MA Plans must receive their Medicare prescription drug benefits from their MA Plan, with the exception of MA PFFS Plans that do not include drug benefits. In general, individuals with ESRD may not enroll in MA Plans.

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

Election Periods

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

- The Initial Coverage Election Period begins 3 months immediately before the individual's entitlement to both Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B or the last day of the individual's Part B IEP. If the beneficiary chooses to join a Medicare health plan during this period, the Plan must accept him or her unless the Plan has reached its member limit;
- The Annual Coordinated Election Period (AEP) occurs each year between October 15 and December 7. The Plan must accept all enrollments during this time unless it has reached its member limits;

- The SEP is when, under certain circumstances, the beneficiary may change MA Plans or return to FFS Medicare; and
- The Medicare Advantage Disenrollment Period (MADP), which gives the beneficiary the opportunity to disenroll from any MA Plan and return to FFS Medicare, occurs from January 1 through February 14 of every year. Disenrollment requests made during this period will be effective the first of the following month. The MADP does not provide an opportunity to join or switch MA Plans. An individual who takes advantage of the MADP may enroll in a stand-alone PDP by February 14, and the enrollment request will be effective on the first of the following month.

Part D – Prescription Drug Benefit

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

Enrollment Periods

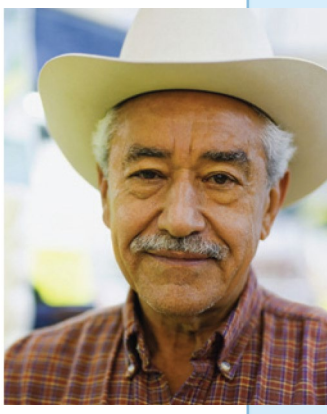
A beneficiary may choose to join or leave a Medicare PDP or MA-PD during the following enrollment periods:

- The IEP is the 7-month period that surrounds the individual's initial eligibility for Part D, beginning 3 months before the month of eligibility and ending on the last day of the third month following the month eligibility began;
- The AEP occurs each year between October 15 and December 7. The Medicare PDP and MA-PDs must accept all enrollments during this time; and
- The SEP, when, under certain circumstances, a beneficiary may enroll in a Part D Plan for the first time or switch to another Part D Plan, although he or she may not disenroll altogether from the Part D Program during a SEP. The effective date of the enrollment request and duration of the SEP are determined by the circumstances that generate the SEP. The following are examples of such circumstances:
  - An individual who permanently moves outside the plan's service area;
  - An individual who enrolls in both Medicare and Medicaid, known as a dual eligible;
  - An individual who moves into, resides in, or moves out of an institution; or
  - Other exceptions that meet "exceptional conditions" as determined by CMS.

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

Some individuals may have to pay an Income Related Monthly Adjusted Amount (IRMAA). If the individual's modified monthly gross income, as reported on his or her U.S. Internal Revenue Service (IRS) tax return from 2 years ago (the most recent tax

return information provided to the SSA by the IRS), is above a certain amount, the individual will pay an IRMAA in addition to his or her normal monthly Part D premium.



ORGANIZATIONS OF INTEREST TO PROVIDERS AND BENEFICIARIES

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

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

Additional information about these organizations is provided below and on page 10.

Social Security Administration (SSA)

The SSA completes the following activities:

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

Department of Health and Human Services (HHS) Office of Inspector General (OIG)

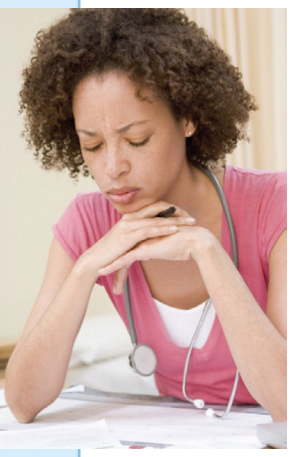
The HHS OIG protects the integrity of HHS programs and the health and welfare of beneficiaries of such programs through a nationwide network of audits, investigations, and other mission-related functions.

State Survey Agencies (SA)

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

Quality Improvement Organizations (QIO)

CMS contracts with one QIO in each State, Washington, D.C., Puerto Rico, and the Virgin Islands. QIOs are private, mostly not-for-profit organizations of practicing doctors and other health care experts who check and improve the care given to Medicare beneficiaries. They review medical records, help beneficiaries with complaints about quality of care, and implement improvements in the quality of care. Beneficiaries may



request an expedited QIO review if they are receiving Medicare-covered services that they believe are ending too soon at a hospital, SNF, Home Health Agency, Comprehensive Outpatient Rehabilitation Facility, or Hospice.

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

End-Stage Renal Disease Network Program

The ESRD Network Program consists of a national network of 18 ESRD Networks that are responsible for each U.S. State, territory, and the District of Columbia. ESRD Networks work with consumers, 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 ESRD Network Program:

- Assures the effective and efficient administration of benefits;
- Improves the quality of care for ESRD patients;
- Collects data to measure quality of care;
- Provides assistance to ESRD patients and providers; and
- Evaluates and resolves patient grievances.

State Health Insurance Assistance Program (SHIP)

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

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

CHAPTER RESOURCES

Centers for Medicare & Medicaid Services

http://www.cms.gov/About-CMS/About-CMS.html on the CMS website.

Medicare Administrative Contractors

Chapter 1 of the “Medicare General Information, Eligibility and Entitlement Manual” (Publication 100-01)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Administrative Contractor Contact Information

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-Interactive-map/index.html on the CMS website.

Medicare Health Insurance Card

Chapter 2 of the "Medicare General Information, Eligibility and Entitlement Manual" (Publication 100-01)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Compilation of the Social Security Laws

http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the SSA website.

Medicare Part A and Part B

Chapter 2 of the "Medicare General Information, Eligibility and Entitlement Manual" (Publication 100-01)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Advantage

http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo on the CMS website.

Private Fee-For-Service Plans

http://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans on the CMS website.

Prescription Drug Coverage

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn on the CMS website.

"Medicare Prescription Drug Benefit Manual" (Publication 100-18)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

U.S. Social Security Administration

http://www.socialsecurity.gov on the SSA website.

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

https://oig.hhs.gov on the OIG website.

State Survey Agencies

"State Operations Manual" (Publication 100-07)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

State Survey Agency Contact Information

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo on the CMS website.

Quality Improvement Organizations

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs on the CMS website.

Chapter 1 of the "Quality Improvement Organization Manual" (Publication 100-10)

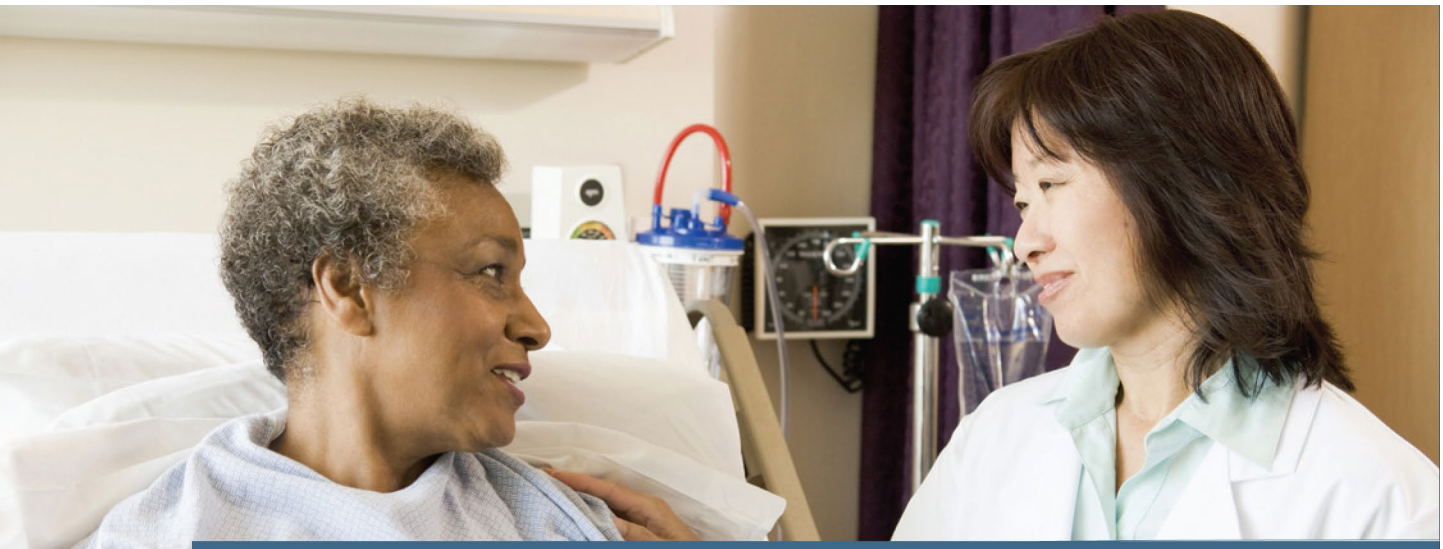
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

End-Stage Renal Disease Network Program

http://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDNetworkOrganizations/index.html on the CMS website.

State Health Insurance and Assistance Programs

http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships on the CMS website.



CHAPTER TWO

BECOMING A MEDICARE PROVIDER OR SUPPLIER

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

MEDICARE PROVIDERS AND SUPPLIERS

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

Institutional Providers

The following provider types enroll under Part A of the Medicare Program:

- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Critical Access Hospitals;
- End-Stage Renal Disease Facilities;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies (HHA) (including sub-units);
- Hospices;
- Hospitals (including acute care psychiatric, rehabilitation, and long-term inpatient services);
- Indian Health Service Facilities;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;

- Outpatient physical therapy/speech pathology providers;
- Religious Nonmedical Health Care Institutions (formerly Christian Science Sanatoriums);
- Rural Health Clinics; and
- Skilled Nursing Facilities (SNF).

Professional Providers and Suppliers

The following provider and supplier types enroll under Part B of the Medicare Program:

- Ambulance service suppliers;
- Ambulatory Surgical Centers (ASC);
- Audiologists;
- Certified diabetes educators;
- Certified nurse-midwives;
- Certified registered nurse anesthetists;
- Clinic/group practices;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- HHAs (outpatient Part B services);
- Hospitals (outpatient services);
- Independent Clinical Laboratories;
- Independent Diagnostic Testing Facilities;
- Intensive Cardiac Rehabilitation Centers;
- Mammography Centers;
- Mass immunization roster billers;
- Nurse practitioners;
- Occupational therapists in private practice;
- Outpatient physical therapists;
- Outpatient speech-language pathology suppliers;
- Physical therapists in private practice;
- Physician assistants;
- Physicians;
- Portable X-Ray Suppliers;
- Radiation Therapy Centers;
- Registered dietitians; and
- SNFs (outpatient services).

Physicians

Under Section 1861(r) of the Social Security Act, physicians are defined as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatry or surgical chiropody, doctors of optometry, or chiropractors.

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

Interns and Residents

Interns and residents include individuals who participate in an approved Graduate Medical Education (GME) Program or physicians who are not in an approved GME Program but are authorized to practice only in a hospital setting (for example, have temporary or restricted licenses or are unlicensed graduates of foreign medical schools). Also included in this definition are interns, residents, and fellows in GME Programs recognized as approved for purposes of Direct GME and Indirect Medical Education payments made by Medicare Administrative Contractors (MAC). Receiving staff or faculty appointments, participating in fellowships, or whether a hospital includes the physicians in its full-time equivalency count of residents does not by itself alter the individual's status as a resident.

Teaching Physicians

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

Non-Physician Practitioners (NPP)

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

- Anesthesiologist assistants;
- Audiologists;
- Certified nurse-midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Occupational therapists in private practice;
- Physical therapists in private practice;
- Physician assistants;
- Psychologists billing independently;
- Registered dietitians or nutrition professionals; or
- Speech-language pathologists in private practice.

ENROLLING IN THE MEDICARE PROGRAM

To enroll in and obtain payment from Medicare, you must apply for:

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

Additional information about applying for a NPI and enrollment in the Medicare Program is provided below and on pages 17 – 22.

1) Applying for a National Provider Identifier (NPI)

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. Health care providers can apply for an NPI in one of three ways:

- Online – For the most efficient application processing and to get your NPI the fastest, you may apply using the web-based application process by logging onto the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the NPPES website;

- Paper Application – You may obtain Form CMS-10114/National Provider Identifier (NPI) Application/Update Form and mail the completed and signed form to the NPI Enumerator. Staff at the NPI Enumerator will enter application data into the NPPES. You may access this form at http://www.cms.gov/medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf on the Centers for Medicare & Medicaid Services (CMS) website. You may also request the form from the NPI Enumerator by: calling 800-465-3203 or TTY 800-692-2326, sending an e-mail to customerservice@npienumerator.com, or sending a letter to:

  NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059; or

- Electronic File Interchange (EFI) – You may agree to have an EFI Organization (EFIO) submit application data on your behalf (through a bulk enumeration process) if an EFIO requests permission to do so.

2) Applying for Enrollment in the Medicare Program

CMS collects information about you and secures documentation to ensure that you are qualified and eligible to enroll in the Medicare Program. You can apply for enrollment by using either:

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

Additional information about the methods to apply for enrollment is provided below and on page 18.

Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) Enrollment Process

You can use Internet-based PECOS to:

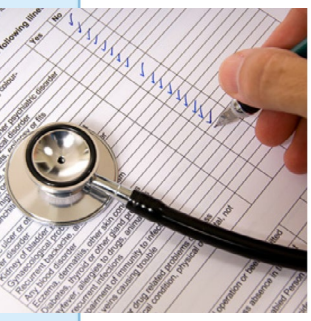
- Submit and electronically sign a Medicare enrollment application;
- Revalidate Medicare enrollment information;
- View or update existing enrollment information;
- Track the status of an enrollment application;
- Add or terminate a reassignment of benefits;
- Reactivate an existing enrollment record; and
- Voluntarily withdraw from the Medicare Program.

If you do not choose to electronically sign the enrollment application, after you submit the application, mail the signed and dated Certification Statement and any supporting documentation to your designated MAC.

Paper Enrollment Application Process

Alternatively, you can apply for enrollment by completing and signing a paper enrollment application form, which is mailed along with any supporting documentation to your designated MAC. Depending upon the provider or supplier type and the enrollment scenario, complete one of the following six CMS enrollment application forms to enroll in the Medicare Program:

- Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application used by institutional providers to apply for enrollment in the Medicare Program or make a change in their enrollment information;
- Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices and other organizational suppliers, except DMEPOS suppliers, to apply for enrollment in the Medicare Program or to make a change in their enrollment information;
- Form CMS-855I/Medicare Enrollment Application for Physicians and Non-Physician Practitioners: Application used by individual physicians or NPPs to apply for enrollment in the Medicare Program or to make a change in their enrollment information;
- Form CMS-855O/Medicare Enrollment Application – Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners: Application used by physicians and NPPs to apply to register in the Medicare Program for the sole purpose of ordering and referring items and/or services for beneficiaries in the Medicare Program or to make a change in their registration information;
- Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to reassign Medicare payments or terminate a reassignment of Medicare benefits after enrollment in the Medicare Program or to make a change in their reassignment of Medicare benefit information; or
- Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers: Application used by suppliers of DMEPOS to apply for enrollment in the Medicare Program or to make a change in their enrollment information.



Additional Required Form and Information

The following form/information is required in addition to the Medicare Enrollment Application:

- Form CMS-588/Electronic Funds Transfer (EFT) Authorization Agreement: Medicare authorization agreement to have payments sent directly to your financial institution through EFT; and
- Your Tax Identification Number and Legal Business Name as reported/ on file with the Internal Revenue Service.

Additional Forms and Documentation That May Be Required

The following forms may be required in addition to the Medicare Enrollment Application:

- Electronic Data Interchange (EDI) Enrollment Form and Centers for Medicare & Medicaid Services EDI Registration Form: Agreements executed when you

submit electronic media claims (EMC) or use EDI, either directly with Medicare or through a billing service or clearinghouse. These forms must be completed prior to submitting EMCs or other EDI transactions to Medicare; and

- Form CMS-460/Medicare Participating Physician or Supplier Agreement: Agreement you will submit if you wish to enroll as a Part B participating provider or supplier. The Participating and Nonparticipating Providers and Suppliers Section on pages 20 – 22 provides additional information about participating in the Medicare Program.

The EDI enrollment and registration forms are also available from MACs and Durable Medical Equipment Medicare Administrative Contractors (DME MAC).

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

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

Additional Requirements for Institutional Providers

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

Reporting Changes to Information in Enrollment Records

You must report changes to information in your Medicare enrollment records within 30 – 90 days of a reportable event. In most cases, you must report an event within 90 days.

You must report the following reportable events within 30 days:

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

Participating and Nonparticipating Providers and Suppliers

There are two types of Part B providers and suppliers: participating and nonparticipating. Additional information about the two types of Part B providers and suppliers is provided below and on pages 21 – 22.

1) Participating Providers and Suppliers:

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

When you complete and sign Form CMS-460/Medicare Participating Physician or Supplier Agreement, you:

- Are formally notifying CMS that you wish to participate in the Medicare Program; and
- Agree to accept assignment on all Part B claims for all covered services for all Medicare beneficiaries.

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

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

Participation is valid for a yearlong period from January 1 through December 31. Active participants get a postcard during the Medicare Participation Open Enrollment Period, which usually begins in mid-November of each year. During this period, you can change your participation status, and that change will be effective on January 1 of the following year. If you wish to continue participating in the Medicare Program, you do not need to sign an agreement each year. The Medicare Participating Physician or Supplier Agreement will remain in effect through December 31 of the calendar year and automatically renews each year unless you decide to terminate the agreement during the open enrollment period. If you have opted-out of Medicare, you will not be able to participate for a 2-year period. Once you sign the Medicare Participating Physician or Supplier Agreement, CMS will rarely honor your decision to change participation status during the year.

2) Nonparticipating Providers and Suppliers:

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

The chart below provides an example of a limiting charge (when a provider or supplier does not accept assignment).

Limiting Charge Example

Amount	Example
PFS Allowed Amount for Procedure "X"	$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure "X"	$190.00 ($200.00 x .95 = 5% lower than PFS allowed amount)
Limiting Charge for Procedure "X"	$218.50 ($190.00 x 1.15 = 115% of PFS allowed amount)
Beneficiary Coinsurance	$ 38.00 ($190.00 x 0.2 = 20% of PFS allowed amount)
Limiting Charge Portion	$ 28.50 ($218.50 - $190.00 = limiting charge less nonparticipating provider/ supplier allowed amount)
Beneficiary Coinsurance Plus Limiting Charge Portion Due to Provider or Supplier	$ 66.50 ($38.00 + $28.50)

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

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

The chart below illustrates the payment amounts that participating and nonparticipating providers and suppliers receive.

Payment Amounts – Participating and Nonparticipating Providers and Suppliers

Amount	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/ Supplier Who Does Not Accept Assignment
Submitted Amount	$250.00	$250.00	$250.00
PFS Allowed Amount	$200.00	$190.00	$190.00
80 Percent of PFS Allowed Amount	$160.00	$152.00	$152.00
Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)	$ 40.00 Coinsurance	$ 38.00 Coinsurance	$ 66.50 Coinsurance + Limiting Charge Portion
Total Payment to Provider/ Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/supplier)	$200.00	$190.00	$218.50

PRIVATE CONTRACTS WITH MEDICARE BENEFICIARIES

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

- Doctors of medicine or osteopathy;
- Doctors of dental surgery or dental medicine;

- Doctors of podiatry; and
- Doctors of optometry.

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

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

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

The opt-out period is for 2 years and can only be terminated early (no later than 90 days after the effective date of the opt-out affidavit) by a physician or practitioner who has not previously opted out. Opt-outs may be renewed for subsequent 2-year periods.

You must opt-out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations, in which case you may treat a beneficiary with whom you do not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ, “Opt-out physician or practitioner emergency or urgent service.”

If you have opted out of Medicare, payment will be made for covered medically necessary items or services that you order if:

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

PROMOTING CULTURAL COMPETENCY IN YOUR PRACTICE

Racial and ethnic minorities now comprise 37 percent of the United States (U.S.) population and are projected to comprise 57 percent of the population in 2060. As these changes unfold, you will more often encounter situations in which you will provide care to and communicate with racially, ethnically, and culturally diverse patients. Addressing a patient's background will assist you in delivering high quality, effective health care and may increase patient satisfaction, increase adherence to treatment protocols, and reduce racial and ethnic health disparities.

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

CHAPTER RESOURCES

Medicare Providers and Suppliers

"Medicare Benefit Policy Manual" (Publication 100-02) and Chapter 5 of the "Medicare General Information, Eligibility and Entitlement Manual" (Publication 100-01)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Compilation of the Social Security Laws

http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the Social Security Administration website.

National Plan and Provider Enumeration System

https://nppes.cms.hhs.gov/NPPES/Welcome.do on the NPPES website.

National Provider Identifier

http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand on the CMS website.

Medicare Learning Network® publication titled "The National Provider Identifier (NPI): What You Need to Know" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPIBooklet.pdf on the CMS website.

Chapter 10 of the "Medicare Program Integrity Manual" (Publication 100-08)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Centers for Medicare & Medicaid Services Forms

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html on the CMS website.

Medicare Provider-Supplier Enrollment

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll on the CMS website.

Chapters 1 and 24 of the "Medicare Claims Processing Manual" (Publication 100-04) and Chapters 10 and 15 of the "Medicare Program Integrity Manual" (Publication 100-08)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Fee-For-Service Provider Enrollment Contact List

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf on the CMS website.

Medicare Administrative Contractor Contact Information

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-Interactive-map/index.html on the CMS website.

Institutional Provider Participation Requirements

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo on the CMS website.

Private Contracts with Medicare Beneficiaries

Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02)

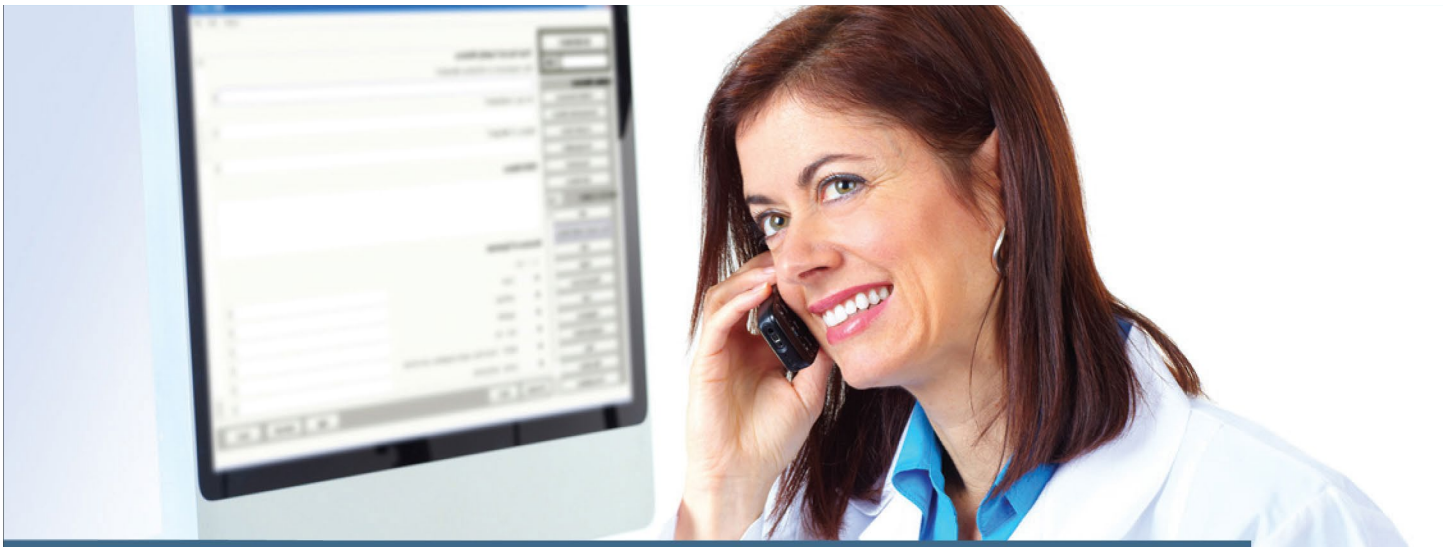
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Cultural Competency

http://mchb.hrsa.gov/training/goal_workforce_diversity.asp on the HHS website.

Provider-Specific Medicare Information

Medicare Learning Network® titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website.



CHAPTER THREE

MEDICARE REIMBURSEMENT

This chapter provides information about Medicare claims; deductibles, coinsurance, and copayments; billing requirements; claims processing; Medicare payment policies; Medicare notices; and other health insurance plans. It also provides helpful resources.

MEDICARE CLAIMS

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

Exceptions to Mandatory Claim Filing

You are not required to file claims on behalf of Medicare beneficiaries when:

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

- The claim is for other unusual services, which are evaluated by MACs on a case-by-case basis;
- The claim is for non-covered services, unless the beneficiary requests submission of a claim to Medicare (a supplemental insurer who pays for these services may require a Medicare claim denial notice prior to making payment);
- The beneficiary signed an Advance Beneficiary Notice of Noncoverage, indicating that no claim should be filed for a specific item or service. The Beneficiary Notices of Noncoverage Section on page 35 provides additional information about these notices;
- You opted-out of the Medicare Program and entered into a private contract with the beneficiary. When you opt-out of Medicare and privately contract with a beneficiary for the purpose of furnishing items or services that would otherwise be covered, you cannot submit a claim for such items or services. Chapter Two of this guide provides additional information about private contracts with Medicare beneficiaries; or
- You have been excluded or debarred from the Medicare Program. When you have been excluded or debarred from the Medicare Program, you cannot submit a claim for your services.

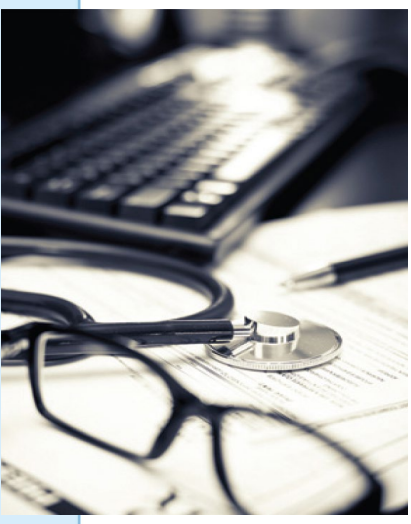
Timely Filing Requirement

Before payment can be made for Medicare-covered services, claims must be filed timely. Claims must be received no later than 1 calendar year from the claim's date of service. Claims filed after the specified timeframe will be denied with no appeal rights. For claims that include span dates of service, claims filing timeliness is determined as follows:

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

Exceptions to the timely filing requirement include the following:

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



Electronic Claims

You must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act format, except in limited situations.

You must complete the Electronic Data Interchange (EDI) Enrollment Form and send it to your designated MAC prior to submitting electronic media claims (EMC). A submitter number, which is required to submit electronic claims, will then be issued. An organization comprised of multiple components that have been assigned more than one Medicare provider identifier may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these identifiers have been assigned. Chapter Two of this guide provides information about enrolling in the Medicare Program.

Electronic Media Claim (EMC) Submissions

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

- Returned to you for correction;
- Suspended in the MAC's system; or
- Corrected by the system (in some cases).

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

Electronic Media Claim (EMC) Submission Alternatives

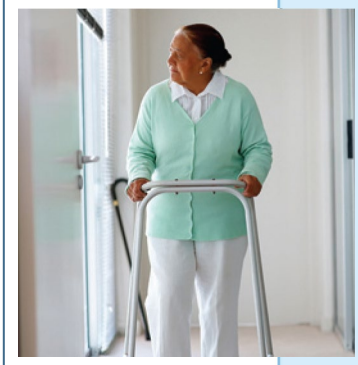
If you do not submit electronic claims using EMC, you may alternatively choose to submit claims through an electronic billing software vendor or clearinghouse, billing agent, or by using Medicare's free billing software. You can obtain a list of electronic billing software vendors and clearinghouses as well as billing software from your MAC.

Paper Claims

In limited situations, you may submit paper claims to Medicare.

Practitioners (physicians and non-physicians) and suppliers use Form CMS-1500 to bill MACs and Durable Medical Equipment Medicare Administrative Contractors (DME MAC). You can order Form CMS-1500 from printing companies, office supply stores, and the U.S. Government Printing Office (GPO), U.S. Government Bookstore. U.S. Government Bookstore orders can be placed by calling 866-512-1800 or visiting http://bookstore.gpo.gov/agency/346 on the GPO website.

Institutional providers use Form CMS-1450, also known as the UB-04, to bill MACs. You can order UB-04 claim forms from the National Uniform Billing Committee (NUBC) at http://www.nubc.org on the NUBC website.



Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Claims

DME MACs have jurisdiction for the following claims:

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

DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

You must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year. Under Fee-For-Service Medicare and MA Private Fee-For-Service (PFFS) Plans, coinsurance is a percentage of covered charges the beneficiary may pay after he or she has met the applicable deductible. You should determine whether the beneficiary has supplemental insurance that will pay for the deductible and coinsurance before billing him or her for them. In some Medicare health plans, a copayment is the amount the beneficiary pays for each medical service.

If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as abuse.

On assigned claims, the beneficiary is responsible for:

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

BILLING REQUIREMENTS

Medicare Secondary Payer (MSP) Program

MSP provisions apply to situations in which a beneficiary's primary health insurance coverage is not Medicare. Before you submit a claim, you must determine whether Medicare is the primary or secondary payer for all inpatient admissions and outpatient encounters, thereby assisting in ensuring the appropriate use of Medicare funds. If another plan, insurer, or program is the primary payer, you must identify such on the claim you submit to Medicare. A primary payer has the primary responsibility for paying a claim. You can determine who the primary payer is by asking the beneficiary about their other health insurance or coverage or using one of the following methods:

- Common Working File (CWF);
- HIPAA Eligibility Transaction System, which will replace CWF in April 2014;
- MAC interactive responsive units; or
- MAC provider Internet portals.

You should not rely on the above methods alone since MSP health care insurance coverage can change quickly.

Coordination of Benefits Contractor (COBC)

The COBC performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. The COBC can assist you with:

- Verifying Medicare's primary or secondary payer status;
- Reporting changes to a beneficiary's health coverage;
- Reporting a beneficiary's accident or injury;
- Reporting potential MSP situations; and
- Obtaining information about Medicare development letters and questionnaires.

The COBC does not process claims for primary or secondary payment or handle any mistaken payment recoveries, claims-specific inquiries, claim or service denials and adjustments, or billing issues. MACs complete these responsibilities.

CLAIMS PROCESSING

After a claim has been submitted and a reimbursement decision has been made, you or your billing agent receive a Remittance Advice (RA). The RA is a notice of payments and adjustments that the MAC produces as a companion to claim payments or an explanation when there is no payment. It features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

1) Denied claim;
2) Zero payment;
3) Partial payment;
4) Reduced payment;
5) Penalty applied;
6) Additional payment; and
7) Supplemental payment.

Both assigned and non-assigned claims may be returned as unprocessable before a reimbursement decision is made if they contain claim errors (for example, incomplete or invalid information). You will receive a letter of explanation or a RA that provides information about claim errors. After the claim has been corrected, you must resubmit it as a new claim within the timely filing period. A claim that has been returned as unprocessable may not be appealed.

You may appeal initial claim determinations, including denials, if you are dissatisfied with the claim determination and file a timely appeal request that contains the necessary information needed to process the request.

If a denial is due to a minor error or omission you made in filing a claim, you may request a reopening to correct such clerical errors. A reopening is separate and distinct from the appeals process. After the claim has been corrected, you must resubmit it within the timely filing period.

MEDICARE PAYMENT POLICIES

A variety of prospective payment systems (PPS), fee schedules, and out-of-network and incentive payments reimburse you for the services and supplies you furnish.

Prospective Payment Systems (PPS)

PPS payments are a predetermined, fixed amount that is based on the classification system of the service. PPSs have been developed for the following:

- Acute Care Hospital Inpatient;
- End-Stage Renal Disease;
- Home Health;
- Hospice;
- Hospital Outpatient;
- Inpatient Psychiatric Facility;
- Inpatient Rehabilitation Facility;
- Long Term Care Hospital; and
- Skilled Nursing Facility.

Fee Schedules (FS)

Fee Schedule (FS) payments are based on a comprehensive list of covered services and their payment rates. FSs have been developed for the following:

- Ambulance;
- Ambulatory Surgical Center;
- Clinical Laboratory;
- DMEPOS; and
- Physician.

Medicare Advantage (MA) Out-of-Network Payments

MA Coordinated Care Plans (for example, Health Maintenance Organizations and Preferred Provider Organizations) and PACE Plans are generally required to reimburse non-contracting providers at least the Fee-For-Service (FFS) rate for Medicare-covered services. PFFS Plans are permitted to establish their own FSs and balance billing rules, which may differ from FFS Medicare payment rates and balance billing rules. Although a non-network PFFS Plan must reimburse all providers at least the FFS Medicare payment rate, if you are treating an enrollee of a PFFS Plan, you should carefully examine the FS and balance billing rules of the PFFS Plan to decide if the terms and conditions of participation warrant a decision to treat and be deemed a contracting provider. Your decision to treat a specific PFFS Plan enrollee is ad hoc and does not require you to treat other PFFS Plan enrollees.

Incentive Payments

You may be eligible for the following Medicare bonus and incentive payments if certain conditions are met:

- Electronic Health Record (EHR) Incentive Program Payment;
- Electronic Prescribing (eRx) Incentive Program Payment;
- Health Professional Shortage Area (HPSA) Bonus Payment;
- Health Professional Shortage Area Surgical Incentive Payment (HSIP);
- Physician Quality Reporting System (PQRS) Incentive Payment; and
- Primary Care Incentive Payment (PCIP).

Additional information about each bonus and incentive payment is provided below and on pages 33 – 35.

Electronic Health Record (EHR) Incentive Program Payment

The Medicare EHR Incentive Program provides incentive payments to eligible professionals (EP), hospitals, and Critical Access Hospitals that demonstrate meaningful use of certified EHR technology. EPs under the Medicare EHR Incentive Program include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

EHR incentive payments for EPs are based on individual practitioners. Providers are only eligible for one incentive payment per year, regardless of how many practices or locations at which they furnish services. Hospital-based EPs are not eligible for incentive payments. An EP is considered hospital-based if 90 percent or more of his or her services are performed in a hospital inpatient (Place of Service code 21) or emergency room (Place of Service code 23) setting. EPs may not earn incentives under the EHR Incentive Program and the eRx Incentive Program at the same time.

Electronic Prescribing (eRx) Incentive Program Payment

EPs who are successful electronic prescribers as defined by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 may be eligible for eRx Incentive Program payments. EPs under the eRx Incentive Program must have prescribing authority and include:

- Physicians – Defined as doctors of medicine or osteopathy, doctors of oral surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, or doctors of chiropractic;
- Practitioners – Defined as anesthesiologist assistants, certified nurse-midwives, certified registered nurse anesthetists, clinical nurse specialists, clinical psychologists, clinical social workers, nurse practitioners, physician assistants, registered dietitians, nutrition professionals, or audiologists; and
- Therapists – Defined as physical therapists, occupational therapists, or qualified speech-language therapists.

Beginning in 2012, EPs who are not successful electronic prescribers may be subject to a payment adjustment on their Part B Medicare Physician Fee Schedule (PFS) covered professional services. Section 132 of MIPPA authorizes CMS to apply this payment adjustment whether or not the EP is planning to participate in the eRx Incentive Program.

Health Professional Shortage Area (HPSA) Bonus Payment

HPSAs are geographic areas, or populations within geographic areas, that lack sufficient health care providers to meet the health care needs of the area or population. HPSAs identify areas of greater need throughout the U.S. so that limited resources can be directed to those areas. Areas are designated as HPSAs by the Health Resources and Services Administration (HRSA) based on census tracts, townships, or counties. Designations are made for primary care, dental, and mental health.

CMS provides a 10 percent bonus payment to physicians who furnish Medicare-covered services to beneficiaries in a geographic HPSA. The bonus is paid quarterly and is based on the amount paid for professional services.

Physicians who furnish services to Medicare beneficiaries in areas designated as primary care geographic HPSAs by HRSA as of December 31 of the prior year are eligible for the Medicare HPSA bonus during the current year. If an area does not have a geographic primary care HPSA designation but has a geographic mental health

HPSA designation, only psychiatrists who furnish services to Medicare beneficiaries in the designated area are eligible for the 10 percent bonus. If an area has both a primary care and a mental health geographic HPSA designation, only one HPSA bonus will be paid.

Health Professional Shortage Area Surgical Incentive Payment (HSIP)

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, general surgeons who furnish a 10- or 90-day global surgical procedure in a ZIP code located in a HPSA are eligible for a 10 percent HPSA bonus payment and a 10 percent HSIP.

Physician Quality Reporting System (PQRS) Incentive Payment

Identified EPs and group practices who satisfactorily report data on quality measures for covered PFS services furnished to Part B beneficiaries may be eligible for an incentive payment under the PQRS. EPs under the PQRS include:

- Physicians – Defined as doctors of medicine or osteopathy, doctors of oral surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, or doctors of chiropractic;
- Practitioners – Defined as anesthesiologist assistants, certified nurse-midwives, certified registered nurse anesthetists, clinical nurse specialists, clinical psychologists, clinical social workers, nurse practitioners, physician assistants, registered dietitians, nutrition professionals, or audiologists; and
- Therapists – Defined as physical therapists, occupational therapists, or qualified speech-language therapists.

Beginning in 2015, EPs and group practices who do not satisfactorily report data on PQRS quality measures for covered professional services will be subject to the following payment adjustments:

- In 2015 – 1.5 percent less than the PFS amount; and
- In 2016 and subsequent years – 2.0 percent less than the PFS amount.

Primary Care Incentive Payment (PCIP)

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, the following physician and non-physician specialties are potentially eligible for a PCIP of 10 percent of paid charges for Part B primary care services furnished to beneficiaries:

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

Only those practitioners enrolled in Medicare with one of the specialties listed above and whose primary care services accounted for at least 60 percent of his or her paid charges under the PFS (excluding hospital inpatient care and emergency department

visits) during the designated period are eligible for the PCIP. Eligibility for the PCIP is determined on an annual basis.

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

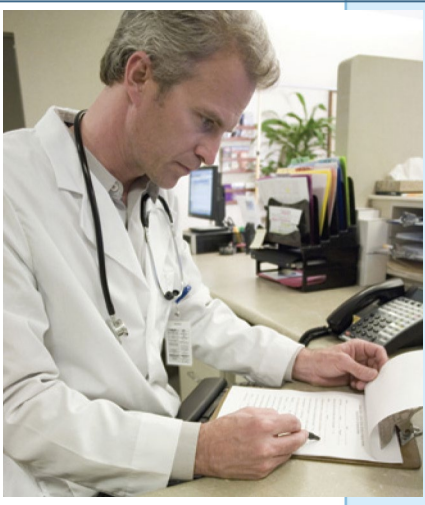
The chart below lists the primary care services that are eligible for the PCIP.

Primary Care Services Eligible for PCIP

Service	Current Procedural Terminology (CPT) Code
New and Established Patient Office or Other Outpatient Visits	CPT codes 99201 – 99215
Nursing Facility Care Visits and Domiciliary, Rest Home, Custodial Care, or Home Care Plan Oversight Services	CPT codes 99304 – 99340
Patient Home Visits	CPT codes 99341 – 99350

MEDICARE NOTICES

Beneficiary Notices of Noncoverage



You must give written notice to a FFS Medicare beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, lack of medical necessity). The following CMS notices are approved for this purpose:

- Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131;
- Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055; and
- Hospital-Issued Notice of Noncoverage (HINN).

The Home Health Advance Beneficiary Notice, Form CMS-R-296, was discontinued on December 9, 2013, and the ABN is used in its place as liability notification.

These notices allow the beneficiary to make an informed decision about whether or not to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If you don't issue the ABN or similar CMS-approved notice when notice is required, the beneficiary cannot be held financially liable if Medicare denies payment. If you properly notify the beneficiary that the item or service may not be covered, you may seek payment from the beneficiary.

You are not required to notify the beneficiary before you provide items or services that are never covered by Medicare (for example, statutorily excluded services). You may, however, choose to issue a voluntary ABN or a similar notice as a courtesy to the beneficiary to alert him or her about their forthcoming financial liability.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier, you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that the beneficiary can be held financially liable for them if payment is denied.

A copy of the ABN or similar CMS-approved notice must be kept in the medical record.

Medicare Summary Notice (MSN)

When a beneficiary receives a Part A or Part B Medicare-covered service, he or she receives a Medicare Summary Notice every 3 months. The MSN explains the following:

- The services and supplies that were billed during the 3-month period;
- What Medicare paid; and
- What the beneficiary may owe.

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

OTHER HEALTH INSURANCE PLANS

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

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

Additional information about each of the health insurance plans is provided below and on page 37.

Medicaid

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

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

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

Medigap

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

Railroad Retirement

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

United Mine Workers of America (UMWA)

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

CHAPTER RESOURCES

Medicare Claims

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans on the Centers for Medicare & Medicaid Services (CMS) website.

DMEPOS and PEN Claims

http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html on the CMS website.

Electronic Data Interchange

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans on the CMS website.

“Medicare Claims Processing Manual” (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Paper Claims

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html on the CMS website.

Deductibles, Coinsurance, and Copayments

Chapter 3 of the "Medicare General Information, Eligibility, and Entitlement Manual" (Publication 100-01) and Chapter 1 of the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Billing Requirements

http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html on the CMS website.

"Medicare General Information, Eligibility, and Entitlement Manual" (Publication 100-01)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

"Medicare Secondary Payer Manual" (Publication 100-05)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Remittance Advice

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html on the CMS website.

HIPAA Eligibility Transaction System

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html on the CMS website.

Coordination of Benefits Contractor

http://cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html on the CMS website.

Health Professional Shortage Area Bonus Payments/Health Professional Shortage Area Surgical Incentive Payments

Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses on the CMS website.

Medicare Learning Network® publication titled "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HPSAfctsht.pdf on the CMS website.

HPSA Designation Criteria and Guidelines

http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria on the HRSA website.

Physician Quality Reporting System

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS on the CMS website.

Chapter 1 of the "Medicare Quality Reporting Incentive Programs Manual" (Publication 100-22)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Electronic Prescribing Incentive Program Payments

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive on the CMS website.

Chapter 2 of the "Medicare Quality Reporting Incentive Programs Manual" (Publication 100-22)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Primary Care Incentive Payments

Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Electronic Health Record Incentive Programs

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms on the CMS website.

Medicare Notices

"Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Beneficiary Notices of Noncoverage

http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website.

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

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html on the CMS website.

Medicaid Program

http://www.medicaid.gov on the Medicaid website.

"State Medicaid Manual" (Publication 45)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html on the CMS website.

Medigap

http://www.cms.gov/Medicare/Health-Plans/Medigap on the CMS website.

Chapter 28 of the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Part B Railroad Medicare

http://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Medicare on the Palmetto GBA website.

Telephone: 800-833-4455

Railroad Retirement Board

https://secure.rrb.gov on the RRB website.

United Mine Workers of America

http://www.umwa.org on the UMWA website.

Telephone: 703-291-2400

CHAPTER FOUR

MEDICARE SERVICES

This chapter discusses Medicare-covered services and items and services that are not covered under the Medicare Program. It also provides helpful resources.

MEDICARE-COVERED SERVICES

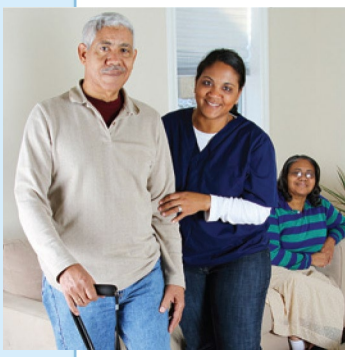
In general, Medicare-covered services are those services that are considered medically reasonable and necessary to the overall diagnosis or treatment of the beneficiary's condition or to improve the functioning of a malformed body member. Services or supplies are considered medically necessary if they meet the standards of good medical practice and are:

- Proper and needed for the diagnosis or treatment of the patient's medical condition;
- Furnished for the diagnosis, direct care, and treatment of the patient's medical condition; and
- Not mainly for the convenience of the patient, provider, or supplier.

Services must also meet specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations. For every service billed, you must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints or specific documentation.

Medicare pays for provider professional services that are furnished in:

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



Part A Inpatient Hospital Services

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

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

Part B Services

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

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

Physician/Non-Physician Practitioner (NPP) Billing for Split/Shared Evaluation and Management (E/M) Services

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

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

Physician Billing for Prolonged Care Services

Physicians may bill for prolonged care services when a physician or NPP:

- Provides direct face-to-face patient contact that is 1 hour beyond the usual service;
- Provides the service in an office or other outpatient setting or in an inpatient setting; and
- Bills for the service on the same day by the same provider as the companion E/M codes.

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

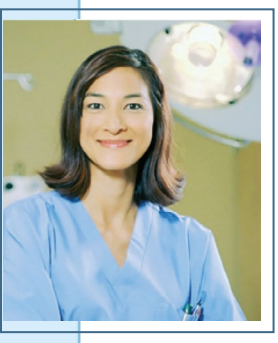
In the office or clinic setting, do not include time the patient spends alone or with office staff.

In the hospital inpatient or outpatient setting, do not include time:

- Spent reviewing charts and consulting with other medical staff; and
- Waiting for results, changes in the patient's condition, end of therapy, and use of facilities.

Physician Billing for Global Surgery

The physician global surgical package paid under the Medicare Physician Fee Schedule (PFS) includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.



Physician Billing for Observation Services

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

The following individuals may bill under the PFS for initial observation care:

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

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

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

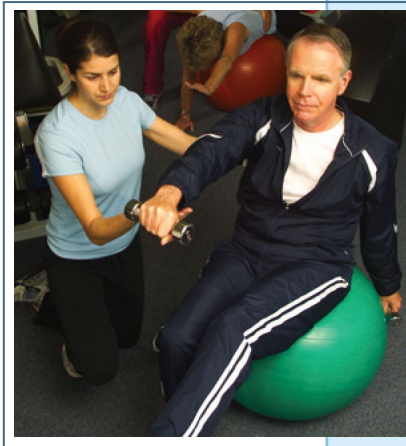
Incident to Provision for Payment of Physician Services

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

1) They Are Commonly Furnished in Physicians' Offices or Clinics

Services and supplies commonly furnished in physicians' offices are covered under the Incident to Provision. Charges for these services and supplies must be included in the physician's bill. To be covered, supplies (including drugs and biologicals) must be an expense to the physician or legal entity billing for the services or supplies.

2) They Are Furnished by the Physician or Auxiliary Personnel Under the Direct Personal Supervision of a Physician



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

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

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

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

3) They Are Commonly Furnished Without Charge (Included in the Physician's Bill) and Are an Expense to the Physician

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

4) They Are An Integral, Although Incidental, Part of the Physician's Professional Service

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

continuing active participation in, and management of, the course of treatment. The physician or another physician in the group practice must be physically present in the same office suite and immediately available to render assistance, if necessary.

Although the rehabilitative services of PT, OT, and SLP have their own benefits under the law, it is also acceptable for these services to be billed by physicians incident to their services if the rules for both the therapy benefit and the incident to benefit are met, with one exception: The staff who provide therapy services under the direct supervision of a physician must be qualified as therapists, with the exception of any licensure requirements that may apply. For example, physical therapists must be licensed and graduates of an approved PT curriculum (unless they meet other requirements for foreign or pre-1977 training). Staff who provide PT services must be graduates of an approved PT curriculum, but not necessarily licensed.

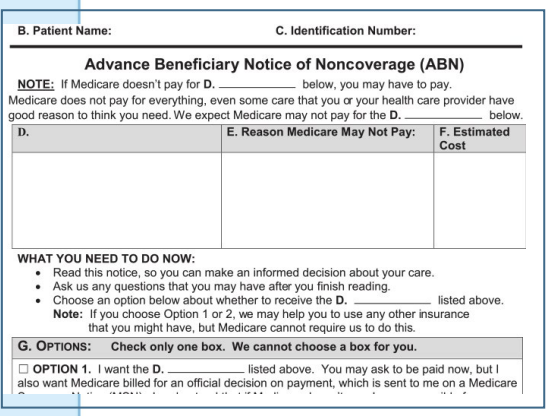
The beneficiary's medical record should document the essential requirements for incident to services.

The requirements for billing incident to services in the hospital setting may be different from the requirements for billing physician incident to services.

ITEMS AND SERVICES THAT ARE NOT COVERED UNDER THE MEDICARE PROGRAM

There are four categories of items and services that are not covered under the Medicare Program:

1) Services and supplies that are not medically reasonable and necessary;
2) Non-covered items and services;
3) Services and supplies that have been denied as bundled or included in the basic allowance of another service; and
4) Items and services reimbursable by other organizations or furnished without charge.



B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare

You must give the beneficiary an Advance Beneficiary Notice of Noncoverage (ABN) or similar CMS-approved notice before providing items or services that are usually covered, but are not expected to be paid by Medicare in a specific instance (for example, lack of medical necessity). You are not required to issue an ABN or similar notice prior to providing items or services that are statutorily excluded or never covered. You may, however, choose to issue a voluntary ABN or similar notice as a courtesy to the beneficiary to alert him or her about their forthcoming financial liability. Chapter Three of this guide provides additional information about the ABN.

CHAPTER RESOURCES

Medicare-Covered Services

"Medicare Benefit Policy Manual" (Publication 100-02) and the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Learning Network® publication titled "Global Surgery" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalISurgery-ICN907166.pdf on the CMS website.

Items and Services Not Covered Under the Medicare Program

Chapter 16 of the "Medicare Benefit Policy Manual" (Publication 100-02)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

MLN publication titled "Items and Services That Are Not Covered Under the Medicare Program" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items_and_Services_Not_Covered_Under_Medicare_BookletICN906765.pdf on the CMS website.

CHAPTER FIVE

PROTECTING THE MEDICARE TRUST FUND

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

COMPREHENSIVE ERROR RATE TESTING (CERT) PROGRAM

The CERT Program identifies programs that may be susceptible to significant improper payments, calculates the Medicare Fee-For-Service (FFS) Program improper payment rate, and estimates the amount of those improper payments.

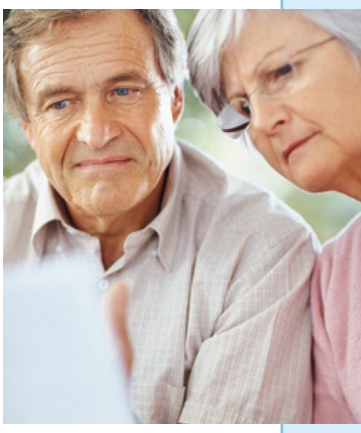
A stratified random sample of claims of FFS is selected and reviewed to determine if they were paid properly under Medicare coverage, coding, and billing rules. A national improper payment amount and corresponding improper payment rate are projected based on results from the sample. Examples of issues that lead to improper payments include:

- No documentation;
- Insufficient documentation;
- Lack of medical necessity;
- Incorrect coding; and
- Duplicate payments.

The CERT Program produces an annual improper payment rate as well as improper payment rates (including underpayments and overpayments) across the following four major claim types:

- Part A (excluding acute inpatient hospital services);
- Part A (acute inpatient hospital services);

- Part B; and
- Durable medical equipment.



The CERT Program may request that you submit medical records for medical review to determine whether the claim was paid properly and met Medicare coverage, coding, and billing rules. If the CERT Program determines that your claim should not have been paid or should have been paid in a different amount, you may appeal the decision through the Medicare appeals process. Chapter Six of this guide provides additional information about appeals.

THE MEDICAL REVIEW (MR) PROGRAM

The goal of the MR Program is to reduce improper payments by preventing the initial payment of claims that do not comply with Medicare's coverage, coding, billing, and payment rules by:

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

Actions that may be taken to prevent and/or address identified improper payments include Progressive Corrective Action, which is an operational principle for conducting medical reviews. It may involve:

- Data analysis;
- Error detection;
- Validation of errors;
- Provider education;
- Determination of review type;
- Sampling claims; and
- Payment recovery.

COVERAGE DETERMINATIONS

There are two types of coverage policies that assist you in coding correctly and billing Medicare only for covered items and services: National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Additional information about the two types of coverage policies is provided below and on pages 50 – 51.

1) National Coverage Determination (NCD)

An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. An NCD is a reasonable and necessary determination made by the Secretary of the United States (U.S.) Department of Health

and Human Services (HHS). A failure to meet the terms of an NCD will make the item or service not reasonable and necessary and is therefore prohibited from payment by Medicare under Section 1862(a)(1)(A) of the Social Security Act (the Act).

A beneficiary also has liability protection under Section 1879 of the Act if he or she did not know in advance that Medicare was prohibited from paying for the item or service. A validly executed and delivered Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, establishes beneficiary knowledge that the item or service may not be covered, thereby allowing the beneficiary to accept liability if Medicare doesn't pay. Chapter Three of this guide provides additional information about the ABN.

Medicare Administrative Contractors (MAC) are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or "Federal Register" Notice. If an NCD and an LCD exist concurrently about the same coverage policy, the NCD takes precedence.

2) Local Coverage Determination (LCD)

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

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

You may submit requests for new or revised LCDs to MACs. The LCD development process is open to the public and includes:

- Developing a draft policy;
- Making the draft available for a minimum comment period of 45 days (if the policy requires a comment period); and
- Soliciting comments and recommendations on the draft, which health care professionals, provider organizations, and the public may electronically submit on MACs' websites.

If a claim is denied by a MAC based on an LCD or an NCD, the beneficiary is notified that the claim was denied and provided the reason(s) for the denial on the Medicare Summary Notice.

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

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

FEDERAL HEALTH CARE FRAUD AND ABUSE

Federal health care fraud and abuse costs taxpayers billions of dollars and puts beneficiaries' health and welfare at risk. CMS, the U.S. Department of Justice, and the HHS Office of Inspector General (OIG) are the government agencies charged with enforcing Federal health care fraud and abuse laws.

In general, Federal health care fraud includes making or causing a false statement or misrepresentation that is material to payment under a Federal health care program.These acts may be committed for the individual's own benefit or for the benefit of another party. Some examples of Federal health care fraud include:

- Knowingly billing for services that were not furnished and/or supplies that were not provided;
- Using an incorrect or inappropriate provider identifier to obtain Medicare payment;
- Signing blank records or certification forms that another entity uses to obtain Medicare payment;
- Falsifying information on applications, medical records, billing statements, cost reports, or any other statement filed with the government or its agents that is material to payment under a Federal health care program;
- Using billing or revenue codes that describe more extensive services than those actually performed (upcoding); and
- Knowingly and willfully paying anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by a Federal health care program.

Abuse includes practices that directly or indirectly result in unnecessary costs to the Medicare Program as a result of deficient management, systems, or controls. It includes any practice that is not consistent with providing beneficiaries with services that are medically necessary and meet professionally recognized standards.

Potential Legal Actions

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

Investigations

A Zone Program Integrity Contractor or Program Safeguard Contractor Benefit Integrity Unit identifies and documents potential health care fraud and abuse and, when appropriate, refers such matters to the OIG for further investigation.

Civil Monetary Penalties

The OIG may seek Civil Monetary Penalties for a wide variety of conduct and is authorized to seek penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $100,000 per violation and assessments may be up to 3 times the amount improperly claimed or the amount of remuneration at issue. In some cases, the OIG may impose exclusion from the Federal health care programs. Some examples of violations for which Civil Monetary Penalties may apply include:

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

Denial or Revocation of Medicare Provider Billing Privileges

CMS has the authority to deny an individual's or entity's application for Medicare provider billing privileges or revoke billing privileges if there is evidence of impropriety (for example, previous felony convictions, falsifying information on the application, or failing to meet State or Federal licensure or certification requirements).

Suspension of Payments

CMS has the authority to suspend payment to individuals and entities when there is reliable information that:

- An overpayment, health care fraud, or willful misrepresentation exists; or
- Payments to be made may not be correct, including a pending investigation of fraud.

During payment suspensions, submitted claims will be processed, and you will be notified about claim determinations. Actual payments due are withheld and may be used to recoup overpaid amounts. You may submit written rebuttals about why a suspension of payment should not be imposed.

Exclusion from Participation

If you have been convicted of any of the following types of criminal offenses, the OIG is legally required to exclude you from participating in all Federal health care programs:

- Felony or misdemeanor convictions related to Medicare and Medicaid fraud as well as any other offenses related to the delivery of items or services under Medicare or any State health care program;
- Felony or misdemeanor convictions related to patient abuse or neglect;
- Felony convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and
- Felony convictions related to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to exclude you from participation on several additional grounds. These grounds include:

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

When you are excluded from participating in the Federal health care programs, Medicare, Medicaid, and other Federal health care programs (for example, TRICARE and the Veterans Health Administration) will not pay you for items or services that you furnish, order, or prescribe. Excluded individuals may not bill directly for treating Medicare and Medicaid patients, and their services may not be billed indirectly through an employer or a group practice. Additionally, you may not employ or contract with an excluded individual or entity, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those excluded employees or contractors.

Excluded Individual and Entity Lists

In general, when you participate in or bill a Federal health care program, you may not employ or contract with an excluded individual or entity. This responsibility requires screening all current and prospective employees and contractors against the OIG's List of Excluded Individuals/Entities (LEIE). The LEIE provides information on individuals and entities that are currently excluded from participation in all Federal health care programs.

The U.S. General Services Administration's System for Award Management (SAM), formerly known as the Excluded Parties List System, identifies parties that are debarred and therefore precluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.

Incentive Reward Program

The Incentive Reward Program encourages individuals to report information about individuals or entities that commit Medicare health care fraud and abuse or other sanctionable activities. The information must lead to a minimum recovery of $100 of Medicare funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or $1,000, whichever amount is lower.

Office of Inspector General Fraud Hotline

To report suspected health care fraud or abuse against Federal health care programs, contact your MAC or the OIG Fraud Hotline as follows:

Mail:	Office of Inspector General U.S. Department of Health and Human Services ATTENTION: HOTLINE P.O. Box 23489 Washington, DC 20026
Telephone:	800-HHS-TIPS (800-447-8477)
Teletypewriter (TTY):	800-377-4950
E-mail:	HHSTips@oig.hhs.gov
Fax:	800-223-8164

CHAPTER RESOURCES

Comprehensive Error Rate Testing Program

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT on the CMS website.

Medical Review Program

"Medicare Program Integrity Manual" (Publication 100-08)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Coverage Determination Process

http://www.cms.gov/Medicare/Coverage/DeterminationProcess on the CMS website.

"National Coverage Determinations Manual" (Publication 100-03) and "Medicare Program Integrity Manual" (Publication 100-08)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Compilation of the Social Security Laws

http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the Social Security Administration website.

Medicare Administrative Contractor Contact Information

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-Interactive-map/index.html on the CMS website.

Health Care Fraud and Abuse

Office of Inspector General https://oig.hhs.gov on the OIG website.

A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse

https://oig.hhs.gov/compliance/physician-education/intro.asp on the OIG website.

"Medicare Program Integrity Manual" (Publication 100-08)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

List of Excluded Individuals/Entities

https://oig.hhs.gov/exclusions/exclusions_list.asp on the OIG website.

System for Award Management

https://www.sam.gov/portal/public/SAM on the SAM website.

CHAPTER SIX

MEDICARE OVERPAYMENTS AND FEE-FOR-SERVICE (FFS) APPEALS

This chapter discusses the Medicare Fee-For-Service Recovery Audit Program, Medicare overpayments, and Fee-For-Service (FFS) appeals. It also provides helpful resources.

MEDICARE FEE-FOR-SERVICE RECOVERY AUDIT PROGRAM

Recovery Auditors (previously known as Recovery Audit Contractors) perform the following functions under the Medicare Fee-For-Service Recovery Audit Program:

- Review FFS Medicare claims on a post-payment basis to determine if improper underpayments or overpayments were made on claims; and
- Review medical records to make an appropriate determination, as needed.

MEDICARE OVERPAYMENTS

A Medicare overpayment is a payment that you have received in excess of the amount due for services under Medicare coverage, coding, and billing rules. Once a determination of an overpayment has been made, the amount of the overpayment becomes a debt owed by the debtor to the Federal government. Federal law requires the Centers for Medicare & Medicaid Services (CMS) to seek recovery of all identified overpayments.

In general, an overpayment may occur due to:

- Duplicate submission of the same service or claim;
- Payment to an incorrect payee;
- Payment for excluded or medically unnecessary services;

- Payment for services that were furnished in a setting that was not appropriate to the beneficiary's medical needs and condition; or
- A pattern of furnishing and billing for excessive services or non-covered services.

If you disagree with an overpayment decision, you may file a request for redetermination with the Medicare Administrative Contractor (MAC) that processed the claim(s) at issue. A redetermination is the first level of appeal, in which MAC staff not involved in making the initial claim determination conduct an independent review of the initial determination. A redetermination request must be filed within 120 calendar days from the date of receipt of the demand letter. An initial determination is the Medicare Summary Notice issued to beneficiaries and the Remittance Advice issued to providers and suppliers. The MAC will generally issue a decision within 60 days of receipt of the redetermination request. To stop the initial recoupment process (which routinely starts on day 41 after the demand is issued), you must file the redetermination request within 30 calendar days from the date of the demand letter. If the redetermination request is received and validated later than 30 calendar days from the date of the demand letter, the recoupment process will stop for those overpayments subject to Section 935(f)(2) of the Medicare Modernization Act; however, any recoupment already taken will not be refunded.

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

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

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

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

You are expected to repay an overpayment as quickly as possible. You may elect to have an overpayment repaid through the immediate recoupment process. This process allows you to avoid paying by check or waiting for the initial recoupment process. A request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter and must specify whether it is for a one-time request for the current overpayment and all future overpayments or for the current overpayment only.

If you cannot refund the total overpayment within 30 days after receiving the first demand letter, an Extended Repayment Schedule (ERS) may be requested. If the request is approved, the ERS will specify the amount to be repaid, including interest, over an established timeframe.

FEE-FOR-SERVICE (FFS) APPEALS

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

A party to an initial determination may be:

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

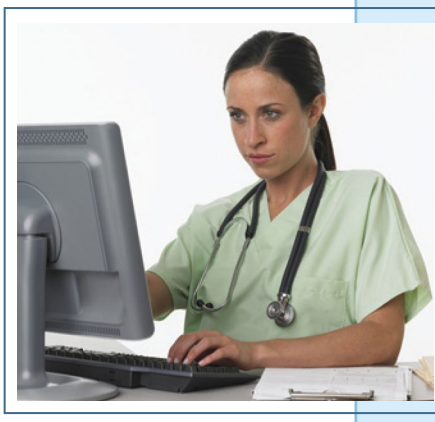
A party to a higher level appeal may be:

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

If a beneficiary dies, leaving no other party available to appeal the determination, you may appeal an initial determination for services furnished if you are not already a party to the appeal.

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

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



If you furnished the items or services that are being appealed, you may be appointed as the beneficiary's representative; however, you may not charge the beneficiary a fee for such representation. You must also waive your right to collect payment from the beneficiary for such items or services when the denial triggers the limitation on liability provisions of Section 1879 of the Act (for example, services not medically reasonable and necessary or services considered custodial in nature).

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

Liability and Appeal Decisions

Liability for appeal decisions is as follows:

- When an original claim denial for both assigned and nonassigned claims is upheld on a review and you knew or could have been expected to know that payment for the service might be denied or reduced, you are held financially liable and must refund any monies collected from the beneficiary within 30 days of the review decision unless a valid Advance Beneficiary Notice of Noncoverage (ABN),

Form CMS-R-131, was properly executed. Chapter Three of this guide provides additional information about ABNs;

- When an original claim denial for an assigned claim is upheld on a review and you and the beneficiary could not have been expected to know that payment for the service might be denied or reduced, payment is made to you;
- When an original claim denial for a nonassigned claim is upheld on a review and it is found that you could not have been expected to know that payment for the service might be denied or reduced, you are notified that payment may be collected from the beneficiary. If the beneficiary is found financially liable, a letter is sent indicating that he or she is responsible for payment;

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

CHAPTER RESOURCES

Medicare Fee-For-Service Recovery Audit Program

Medicare Learning Network® publication titled “The Medicare Fee-For-Service Recovery Audit Program Process” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Fee-For-Service-Recovery-Audit-Program-Process-Educational-Tool-ICN908524.pdf on the CMS website.

Recovery Auditor Contact Information

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Contact-Information-AbbrState-Apr2013.pdf on the CMS website.

Medicare Overpayments

Chapter 34 of the "Medicare Claims Processing Manual" (Publication 100-04) and Chapters 3 and 4 of the "Medicare Financial Management Manual" (Publication 100-06)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

"Code of Federal Regulations"

http://www.gpo.gov/fdsys/search/home.action on the Government Printing Office website.

Fee-For-Service Appeals

http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals on the CMS website.

http://www.hhs.gov/omha on the Department of Health and Human Services (HHS) website.

Chapter 29 of the "Medicare Claims Processing Manual" (Publication 100-04)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Compilation of the Social Security Laws

http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the Social Security Administration website.

Appeals Forms

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html on the CMS website.

http://www.hhs.gov/omha on the HHS website.

CHAPTER SEVEN

PROVIDER OUTREACH AND EDUCATION (POE)

This chapter discusses the Medicare Learning Network® (MLN) and Medicare Administrative Contractor (MAC) Provider Outreach and Education (POE) Programs. It also provides helpful resources.

THE MEDICARE LEARNING NETWORK® (MLN)

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

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

MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) PROVIDER OUTREACH AND EDUCATION (POE) PROGRAMS

MAC POE Programs offer you the following education on the fundamentals of the Medicare Program:

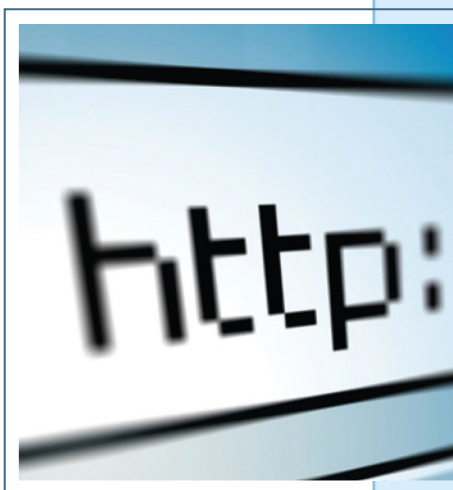
- National and local policies and procedures;
- New Medicare initiatives;
- Significant changes to the Medicare Program; and
- Issues identified through:

- Analyses of provider inquiries;
- Claim submission errors;
- Medical Review data; and
- Comprehensive Error Rate Testing and Recovery Auditor data.

MACs use the following communication channels and mechanisms to offer you Medicare Program information:

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

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



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

CHAPTER RESOURCES

The Medicare Learning Network®

http://go.cms.gov/MLNGenInfo on the CMS website.

All Available MLN Products

“Medicare Learning Network® Catalog of Products” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right with your mobile device.

Medicare Administrative Contractor Provider Outreach and Education Programs

Chapter 6 of the "Medicare Contractor Beneficiary and Provider Communications Manual" (Publication 100-09)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Medicare Administrative Contractor Contact Information

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-Interactive-map/index.html on the CMS website.

GLOSSARY

A

Abuse

Includes practices that directly or indirectly result in unnecessary costs to the Medicare Program as a result of deficient management, systems, or controls. It includes any practice that is not consistent with providing beneficiaries with services that are medically necessary and meet professionally recognized standards.

Advance Beneficiary Notice of Noncoverage

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

Assignment

When you are paid the Medicare-allowed amount as payment in full for all Part B claims for all covered services for all Medicare beneficiaries.

C

"Code of Federal Regulations"

The official compilation of Federal rules and requirements.

Coinsurance

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

Comprehensive Error Rate Testing Program

A program that identifies programs that may be susceptible to significant improper payments, calculates the Medicare Fee-For-Service Program improper payment rate, and estimates the amount of those improper payments.

Copayment

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

D

Deductible

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

Durable Medical Equipment

Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist and that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Is generally not useful to an individual in the absence of an illness or injury; and
- Is appropriate for use in the home.

E

Electronic Health Record Incentive Program Payment

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

Electronic Prescribing Incentive Program Payment

An incentive payment that eligible professionals who are successful electronic prescribers may be eligible for.

F

Federal Health Care Fraud

In general, includes making or causing a false statement or misrepresentation that is material to payment under a Federal health care program.

Fee-For-Service Appeal

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

Fee Schedule

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

G

Global Surgery

A package that includes all necessary services normally furnished by a surgeon before, during, and after a procedure.

H

Health Professional Shortage Area Incentive Payment

A 10 percent bonus payment made to physicians who furnish Medicare-covered services to beneficiaries in a geographic Health Professional Shortage Area.

Health Professional Shortage Area Surgical Incentive Payment

A 10 percent incentive payment that general surgeons who furnish a 10- or 90-day global surgical procedure in a ZIP code located in a Health Professional Shortage Area (HPSA) are eligible for. This payment is in addition to the 10 percent HPSA incentive payment.

I

Incentive Reward Program

A program that encourages individuals to report information about individuals or entities that commit Medicare health care fraud and abuse or other sanctionable activities.

Incident to Provision

The following four requirements must be met for services and supplies to be covered incident to the services of a physician: They are commonly furnished in physicians' offices or clinics; they are furnished by the physician or auxiliary personnel under the direct personal supervision of a physician; they are commonly furnished without charge (included in the physician's bill) and are an expense to the physician; and they are an integral, although incidental, part of the physician's professional service.

Interns and Residents

Individuals who participate in an approved Graduate Medical Education (GME) Program or physicians who are not in an approved GME Program but are authorized to practice only in a hospital setting (for example, have temporary or restricted licenses or are unlicensed graduates of foreign medical schools). Also included in this definition are interns, residents, and fellows in GME Programs recognized as approved for purposes of Direct GME and Indirect Medical Education payments made by Medicare Administrative Contractors.

L

Local Coverage Determination

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

M

Medicaid

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

Medically Necessary

Services or supplies that meet the standards of good medical practice and are proper and needed for the diagnosis or treatment of the beneficiary's medical condition; furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; and are not mainly for the convenience of the beneficiary, provider, or supplier.

Medical Review Program

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

Medicare Administrative Contractor

Organizations that perform claims processing and related administrative functions under contract with the Centers for Medicare & Medicaid Services and include Fee-For-Service Contractors, Medicare Advantage Plan Contractors, and Medicare Prescription Drug Plan Contractors.

Medicare-Covered Service

A service that is medically reasonable and necessary to the overall diagnosis or treatment of the beneficiary's condition or to improve the functioning of a malformed body member.

Medicare Learning Network®

A Centers for Medicare & Medicaid Services program that offers a variety of training and educational materials that break down Medicare policy into plain language.

Medicare Overpayment

A payment you have received in excess of the amount due for services under Medicare coverage, coding, and billing rules.

Medicare Part A

Hospital insurance that helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility following a qualifying hospital stay, some Home Health care, and Hospice care.

Medicare Part B

Medical insurance that helps pay for medically necessary services furnished by physicians in a variety of medical settings; many preventive services; Home Health care for individuals who do not have Part A; ambulance services; clinical laboratory and diagnostic services; surgical supplies; durable medical equipment, prosthetics, orthotics, and supplies; hospital outpatient services; and services furnished by practitioners with limited licensing.

Medicare Part C (Medicare Advantage)

Another health plan choice available to beneficiaries run by Medicare-approved private insurance companies. Most of these organizations arrange for or directly provide health care items or services to the beneficiary who is entitled to Part A and enrolled in Part B, permanently resides in the service area of the Medicare Advantage (MA) Plan, and elects to enroll in a MA Plan.

Medicare Part D (Prescription Drug Benefit)

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

Medicare Summary Notice

A notice that a beneficiary receives every 3 months when he or she receives a Part A or Part B Medicare-covered service. It explains the services and supplies that were billed during the 3-month period, what Medicare paid, and what the beneficiary may owe.

Medigap

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

N

National Coverage Determination

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

National Provider Identifier

A Health Insurance Portability and Accountability Act Administrative Simplification Standard and a unique identification number for covered health care providers.

Nonparticipating Provider or Supplier

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

Non-Physician Practitioners

Defined as any of the following to the extent that the individual is legally authorized to practice by the State and otherwise meets Medicare requirements: anesthesiologist assistants, audiologists, certified nurse-midwives, certified registered nurse anesthetists, clinical nurse specialists, clinical psychologists, clinical social workers, nurse

practitioners, occupational therapists in private practice, physical therapists in private practice, physician assistants, psychologists billing independently, registered dietitians or nutrition professionals, or speech-language pathologists in private practice.

O

Observation Services

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

P

Participating Provider or Supplier

A Part B provider or supplier who has indicated that he or she wishes to participate in the Medicare Program by completing and signing Form CMS-460/Medicare Participating Physician or Supplier Agreement and agrees to accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries.

Physician Quality Reporting System Incentive Payment

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

Physicians

Defined as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatry or surgical chiropody, doctors of optometry, or chiropractors. In addition, the Medicare physician must be legally authorized to practice by a State in which he or she performs this function.

Primary Care Incentive Payment

A payment of 10 percent of paid charges for Part B primary care services furnished to beneficiaries that family, internal, geriatric, and pediatric medicine physicians; clinical nurse specialists; nurse practitioners; and physician assistants are potentially eligible for.

Prolonged Care

Occurs when a physician or non-physician practitioner provides direct face-to-face patient contact that is 1 hour beyond the usual service, provides the service in an office or other outpatient setting or in an inpatient setting, and bills for the service on the same day by the same provider as the companion evaluation and management codes.

Prospective Payment System

Method of reimbursement in which Medicare payment is a predetermined, fixed amount that is based on the classification system of the service.

R

Remittance Advice

A notice of payments and adjustments that the Medicare Administrative Contractor produces as a companion to claim payments or an explanation when there is no payment.

S

Split/Shared Service

An encounter where a physician and a non-physician practitioner each personally perform a portion of an evaluation and management visit.

T

Teaching Physicians

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

Timely Filing Requirement

Requirement that Medicare claims must be received no later than 1 calendar year from the claim's date of service (an exception may apply if certain conditions are met).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