MEDICARE

PART B

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Physician Assistant
Nurse Practitioner
Clinical Nurse Specialist
Certified Nurse-Midwife

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PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), CLINICAL NURSE SPECIALIST (CNS), AND CERTIFIED NURSE-MIDWIFE (CNM) GUIDE

INTRODUCTION

The Provider Education and Outreach Team at NHIC, Corp., developed this guide to provide you with Medicare Part B Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse Midwife billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), *Medicare B Resource* (quarterly provider newsletter), and special program mailings provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-2, Chapter 15, and Publication 100-4, Chapter 12, of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at http://www.cms.hhs.gov/manuals

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PHYSICIAN ASSISTANT (PA) SERVICES

General Information

The professional services of a Physician Assistant (PA) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable State licensure laws, but only if no facility or other provider charges or is paid with respect to the furnishing of such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for PAs

In order to furnish covered services, the PA must meet the conditions as follows:

- Graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)); or
- Passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the State to practice as a physician assistant.

Covered Services

Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law). The services of a PA may be covered under Part B, if all of the following requirements are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets all the PA qualifications,
- They are performed under the general supervision of an MD/DO;
- The PA is legally authorized to perform the services in the state in which they are performed; and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.

Types of PA Services That May Be Covered

State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. Also, if authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician. Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

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Services Otherwise Excluded From Coverage

PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical exams, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a PA's scope of practice under State law.

Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.

Employment Relationship

Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories. If the employer of the PA is a professional corporation or other duly qualified legal entity (such as a limited liability company or a limited liability partnership), properly formed, authorized and licensed under State laws and regulations, that permits PA ownership in such corporation or entity as a stockholder or member, that corporation or entity as the employer may bill for PA services even if a PA is a stockholder or officer of the entity, as long as the entity is entitled to enroll as a "provider of services" or a "supplier of services" in the Medicare program. PAs may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to sole proprietorships or general partnerships.

Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. A leasing agency and staffing company do not qualify under the Medicare program as a "provider of services" or "supplier of services". Payment for PA services is made only to the PA's employer, whether the PA is employed as a W-2 employee or as a 1099 employee. While a PA has an option in terms of selecting employment arrangements, only the "employer" can bill a carrier for the PA's services.

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NURSE PRACTITIONER (NP) SERVICES

General Information

The professional services of a Nurse Practitioner (NP) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable state licensure laws. Nurse Practitioners are also authorized to bill the Medicare program directly for their services when furnished in any area or setting. However, no separate payment will be made when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for NPs

NPs who applied for a Medicare billing for the first time from January 1, 2001, through December 31, 2002 must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

NPs who apply for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law;
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
- Possess a master's degree in nursing.

The following organizations are recognized national certifying bodies:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- National Certification Board of Pediatric Nurse Practitioners and Nurses;
- Oncology Nurses Certification Corporation; and
- Critical Care Certification Corporation

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Covered Services

Coverage is limited to the services a NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a NP may be covered under Part B if all of the following conditions are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets the definition of a NP;
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with a MD/DO, and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.

Types of NP Services That May Be Covered

State law or regulation governing a NP's scope of practice in the State in which the services are performed applies. Examples of the types of services that NPs may furnish include services that traditionally have been reserved to physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

Medicare pays for nurse practitioner services to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as his/her attending physician with the exception of certifying the terminal illness with a prognosis of 6 months or less. A physician will be required to certify the terminal illness and 6 month prognosis.

Services Otherwise Excluded From Coverage

NP services may not be covered if they are otherwise excluded from coverage even though a NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical exams, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a NP's scope of practice under State law.

Collaboration

Collaboration is a process in which a NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

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CLINICAL NURSE SPECIALIST (CNS) SERVICES

General Information

The professional services of a Clinical Nurse Specialist (CNS) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable state licensure laws. Clinical Nurse Specialists are also authorized to bill the Medicare program directly for their services when furnished in any area or setting. However, no separate payment will be made when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for CNSs

In order to furnish covered services, a CNS must meet the conditions as follows:

- Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;
- Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Covered Services

Coverage is limited to the services a CNS is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law). The services of a CNS may be covered under Part B if all of the following conditions are met:

- They are the types of services that are considered as physician's services if furnished by an MD/DO;
- They are furnished by a person who meets the CNS qualifications;
- The CNS is legally authorized to furnish the services in the State in which they are performed;
- They are furnished in collaboration with an MD/DO as required by State law; and
- They are not otherwise excluded from coverage because of one of the statutory exclusions.

Types of CNS Services that May be Covered

State law or regulations governing a CNS's scope of practice in the State in which the services are furnished applies. Examples of the types of services that CNSs may furnish include services that traditionally have been reserved for physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of his or her State license, CNSs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

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Services Otherwise Excluded From Coverage

A CNS's services are not covered if they are otherwise excluded from coverage even though a CNS may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and routine physical exams and services that are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a CNS's scope of practice under State law.

Collaboration

Collaboration is a process in which a CNS works with one or more physicians (MD/DO) to deliver health care services within the scope of the CNSs professional expertise with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by the CNS documenting his or her scope of practice and indicating the relationships that the CNS has with physicians to deal with issues outside the CNS's scope of practice. The collaborating physician does not need to be present with the CNS when the services are furnished or to make an independent evaluation of each patient who is seen by the CNS.

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CERTIFIED NURSE-MIDWIFE (CNM) SERVICES

General Information

The professional services of a Certified Nurse-Midwife (CNM) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. There is no restriction on the place of service. The services are covered if provided in the CNM's office, in the patient's home, or in a hospital or other facility, such as a clinic or birthing center owned or operated by a CNM.

Qualifications for CNM

A CNM is a registered nurse who has successfully completed a program of study and clinical experience in nurse-midwifery, meeting guidelines prescribed by the Secretary, or who has been certified by an organization recognized by the Secretary. The Secretary has recognized certification by the American College of Nurse-Midwives and State qualifying requirements in those States that specify a program of education and clinical experience for nurse-midwives for these purposes.

In order to furnish covered services, the CNM must meet the conditions as follows:

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

Covered Services

Coverage is available for services furnished by a CNM that he or she is legally authorized to perform in the State in which the services are furnished and that would otherwise be covered if furnished by a physician, including obstetrical and gynecological services.

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Services Otherwise Excluded From Coverage

The services of CNMs are not covered if they are otherwise excluded from Medicare coverage even though a CNM is authorized by State law to perform them. For example, the Medicare program excludes from coverage routine physical checkups and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within the CNM's scope of practice.

Coverage of service to the newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother's eligibility.

Relationship with Physician

Most States have licensure and other requirements applicable to CNMs. For example, some require that the CNM have an arrangement with a physician for the referral of the patient in the event a problem develops that requires medical attention. Others may require that the CNM function under the general supervision of a physician. Although these and similar State requirements must be met in order for the CNM to provide Medicare covered care, they have no effect on the CNM's right to personally bill for and receive direct Medicare payment. That is, billing does not have to flow through a physician or facility.

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INCIDENT-TO SERVICES

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services. A practitioner includes a physician assistant, nurse practitioner, clinical nurse specialist, and certified nurse-midwife. For purposes of this section physician also means practitioner/PA,NP,CNS, CNM. Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services must be performed under the physician's direct supervision. Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.

To be covered incident to the services of a physician, services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics;
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

It is within Medicare benefit categories that a PA, NP, CNS, or CNM may enroll in the Medicare program and provide services without direct supervision and have the service covered. However, these specialties may opt to provide services incident to an MD or DO. It is not within Medicare benefit categories for auxiliary personnel such as registered nurses or licensed practical nurses to enroll in the Medicare program or provide services without direct supervision. Such auxiliary personnel may only provide services under the incident to guidelines.

Auxiliary personnel is defined as any individual who is acting 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. Where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel is performing services.

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If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision. For hospital patients (inpatient, outpatient, ER), and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services. Such services can be covered only under the hospital or SNF benefit.

To summarize, incident to services are allowable in the office and home setting only. A PA, NP, CNS, and CNM can provide services incident to an MD or DO if they choose. For services provided by auxiliary personnel to be covered incident to, the physician or non-physician practitioner (NPP) must perform the initial service, diagnose the patient's medical condition, develop a treatment plan, and remain actively involved in the management of the care of the patient. NHIC requires the physician or non-physician practitioner to review the progress and co-sign the charts. The physician or non-physician practitioner accepts responsibility and liability for the incident to services.

Incident-To for Homebound Patients

In some medically underserved areas there are only a few physicians available to provide services over broad geographic areas or to a large patient population. The lack of medical personnel (and, in many instances, a home health agency servicing the area) significantly reduces the availability of certain medical services to homebound patients. Some physicians and physician-directed clinics, therefore, call upon nurses and other paramedical personnel to provide these services under general (rather than direct) supervision. In some areas, such practice has tended to become the accepted method of delivery of these services.
An individual does not have to be bedridden to be considered as confined to home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving his or her home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration.

The direct supervision criterion is not applicable when certain services are performed by personnel meeting any pertinent State requirements and where the criteria listed below are also met:

- The patient is homebound; i.e., confined to his or her home.
- The service is an integral part of the physician's service to the patient (the patient must be one the physician is treating), and is performed under general physician supervision by employees of the physician or clinic.
- The services are included in the physician's/clinic's bill, and the physician or clinic has incurred an expense for them.

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- The services of the auxiliary personnel are required for the patient's care; that is, they are reasonable and necessary.
- When the service can be furnished by a Home Health Agency (HHA) in the local area, it cannot be covered.

Note: General supervision means that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control. The physician orders the service(s) to be performed, and contact is maintained between the auxiliary personnel and the physician, e.g., the employee contacts the physician directly if additional instructions are needed, and the physician must retain professional responsibility for the service.

Covered Services

When the above requirements are met, the direct supervision requirement is not applicable to the following services:

- Injections;
- Venipuncture;
- EKGs;
- Therapeutic exercises;
- Insertion and sterile irrigation of a catheter;
- Changing of catheters and collection of catheterized specimen for urinalysis and culture;
- Dressing changes, e.g., the most common chronic conditions that may need dressing changes are decubitus care and gangrene;
- Replacement and/or insertion of nasogastric tubes;
- Removal of fecal impaction, including enemas;
- Sputum collection for gram stain and culture, and possible acid-fast and/or fungal stain and culture;
- Paraffin bath therapy for hands and/or feet in rheumatoid arthritis or osteoarthritis;
- Teaching and training the patient for:
    a. The care of colostomy and ileostomy;
    b. The care of permanent tracheostomy;
    c. Testing urine and care of the feet (diabetic patients only); and
    d. Blood pressure monitoring.

SPLIT/SHARED E/M SERVICE

Medically Necessary Encounter

A split/shared E/M visit is defined as a medically necessary encounter with a patient where the physician and a qualified non-physician practitioner (NPP) each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to consultation services, critical care services, or procedures. A split/shared E/M visit cannot be reported in the SNF/NF settings.

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Office Setting
In the office/clinic setting, when only the physician performs the E/M service the service must be reported using the physician's PIN/NPI. When an E/M service is a split/shared encounter between a physician and a NPP and the service is for an established patient and previously diagnosed medical condition, the service can be billed under the physician's PIN/NPI. All incident to requirements must be met. When the service is split/shared between the physician and the NPP and the service is for a new patient or new medical condition, the service must be billed under the NPP's PIN/NPI. Incident to requirements do not apply since this is a new patient or new condition.

Hospital Setting
In the hospital setting, when the service is split/shared between a physician and a NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's PIN/NPI. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's PIN/NPI.

Examples:
In an office setting, the NPP performs a portion of the E/M encounter and the physician completes the service. If the incident to requirements are met, the physician reports the service. If the incident to requirements are not applicable, the NPP reports the service

In a hospital setting, if the NPP sees an inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, either the physician or NPP may report the service.

SERVICES RENDERED IN A NURSING FACILITY

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs.

The initial visit in a SNF must be performed by the physician. The initial visit is defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission. Further, per the Long Term Care regulations, the physician may not delegate a task that the physician must personally perform. Therefore, the physician may not delegate the initial visit in a SNF.

The initial visit in the NF may be performed by a qualified non-physician practitioner, who is not employed by the facility, when the State law permits this. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration (for NP, CNS) and physician supervision (for PA) shall be met.

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Other medically necessary E/M visits for the diagnosis or treatment of an illness or injury may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified non-physician practitioner may perform these medically necessary E/M visits if all the requirements for collaboration (for NP, CNS), general physician supervision (for PA), licensure and billing are met.

Payment is made under the physician fee schedule for federally mandated visits. Following the initial visit, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Subsequent nursing facility care codes shall be used to report federally mandated E/M visits as well as medically necessary E/M visits. The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The non-physician practitioner shall bill only one E/M visit.

Non-physician practitioners are not able to bill for more frequent visits than those that are medically necessary, or federally mandated, even if a state requires more frequent visits. Payment for the services of non-physician practitioners who are employed by a SNF and furnished to SNF residents, is bundled under the per diem rate (Part A) and are not separately billable. Payment for the services of non-physician practitioners who are not employed by a SNF and furnished to SNF residents, are allowed under Part B.

Non-physician practitioners may not sign the initial orders for a SNF resident. However, they may write initial orders for a SNF resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician. A physician does not have to sign orders if no orders are necessary or written. For example, for Federally required visits, it is not always necessary to write orders, so no physician signature would be required.

NPs and CNSs who are not employed by the SNF may certify and recertify that the services the beneficiary requires may only be performed in the SNF. By statute, PAs may not sign SNF certifications/recertifications. In order to sign certifications/recertifications, the NP or CNS may not have a direct or indirect employment relationship with the SNF, for example, they may not be employed by an organization related to the SNF.

SERVICES IN A RURAL HEALTH CENTER (RHC) OR A FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Separate payment for the professional services provided in a RHC or FQHC setting is not permitted. These services are bundled with other facility services when furnished to patients under the RHC or FQHC benefits. The payment made to these facilities under the all-inclusive rate specifically accounts for the services for the non-physician practitioner because the facility payment rate reflects the costs for these services.

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REIMBURSEMENT RATE

PAs, NPs, CNSs

The payment for PAs, NPs and CNSs is 80 percent of the lesser of either the actual charge or 85 percent of the physician's fee schedule amount. For assistant at surgery services, payment equals 80 percent of the lesser of either the actual charge or 85 percent of the physicians fee schedule amount paid to a physician serving as an assistant at surgery. A physician serving as an assistant at surgery receives 16 percent of the physician fee schedule amount. The PA, NP, and CNS allowance is 85 percent of the 16 percent (13.6 percent of the physician fee schedule).

CNM

The payment for CNM services is 80 percent of the lesser of either the actual charge or 65 percent of the physician's fee schedule amount. When a CNM is providing care to a Medicare beneficiary and the collaborating physician provides some of the services, the fee paid to the CNM is based on the portion of the global fee that would have been paid to the physician for the service provided by the CNM. For example, a CNM requests that the physician examine the beneficiary, per their collaborative agreement, prior to the delivery. The CNM has provided the ante partum care and intends to perform the delivery and post partum care. The physician fee schedule amount for the physician's total obstetrical care (global fee) is $1,000. The physician fee schedule amount for the physician's office visit is $30. The following calculation shows the maximum allowance for the CNM's service:

Physician fee schedule amount for total obstetrical care	$1,000.00
Physician fee schedule amount for visit	$ -100.00
Result	$ 900.00
Fee schedule amount for nurse-midwife (65% x $900)	$ 585.00

Therefore, the CNM would be paid no more than 80 percent of $585.00 for the care of the beneficiary. This calculation also applies when a physician provides most of the services and calls in a CNM to provide a portion of the care. Physicians and CNMs use reduced service modifiers (modifier 52) to report that they have not provided all the services covered by the global allowance.

ASSISTANT AT SURGERY

The 'AS' modifier is defined as physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. Assistant at surgery claims for PAs, NPs and CNSs must be submitted with the AS modifier.

The '80' modifier is defined as surgical assistant services. The '81' modifier is defined as minimum surgical assistant services. Assistant at surgery claims for CNMs must be submitted with one of these modifiers.

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OUTPATIENT MENTAL HEALTH LIMITATION

The outpatient mental health limitation applies to all covered mental health therapeutic services furnished by PAs, NPs, CNSs, and CNMs when performed in an outpatient setting. The limitation does not apply to services performed in an inpatient setting (inpatient hospital, inpatient psychiatric facility or comprehensive outpatient rehabilitation facility). The reduction is 62.5 percent applied after the 85 percent.

BILLING REQUIREMENTS

Mandatory Assignment

Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse-Midwives must accept assignment on all claims. Mandatory assignment means the PA, NP, CNS, and CNM must accept the Medicare allowed amount as payment in full and may not bill or collect from the beneficiary any amount other than unmet deductible and / or coinsurance amounts.

Incident to Services

When a PA, NP, CNS or CNM renders services incident to a physician, submit the claim under the supervising physician's provider number. Services are billed as if the physician personally performed them. When auxiliary personnel render services incident to a PA, NP, CNS, or CNM submit the claim under the supervising PA, NP, CNS. or CNM. Services are billed as if the PA, NP, CNS, or CNM personally performed the service. All incident to requirements must be met.

Provider Identification Numbers/National Provider Identifier (PIN/NPI)

Physician Assistant

Payment of PA services is made only to the PA' s employer. If the employer is a group practice, the group must include their group provider number in Item 33, including name and address and list the individual PA's provider number in Item 24j on the CMS 1500 claim form or electronic equivalent.

If the employer is a sole proprietor, he/she must include his/her individual provider number in Item 33, including the name and address and list the individual PA's provider number in 24j on the CMS 1500 claim form or electronic equivalent.

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Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse-Midwife

NPs, CNSs, and CNMs can bill the Medicare program directly for their services or reassign payments to an employer. When NPs, CNSs, and CNMs are rendering services and wish to receive payment directly, the provider number of the NP, CNS, or CNM must be entered in Item 33, including the name and address, on the CMS 1500 claim form or electronic equivalent.

If the employer is a group practice, the group must include their group provider number in Item 33, including name and address and list the individual NP, CNS, or CNM number in Item 24J on the CMS 1500 claim form or electronic equivalent.

In New England, if the employer is a sole proprietor, he/she must include his/her individual provider number in Item 33, including the name and address and list the individual NP, CNS, or CNM provider number in 24J on the CMS 1500 claim form or electronic equivalent. In California, a group number is assigned, and all billings must be submitted with the group practice instructions.

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NATIONAL CORRECT CODING INITIATIVE

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. Thus, to be held liable for denied charge (s), the beneficiary must be given appropriate written advance notice of the likelihood of non-coverage and agree to pay for services. A written notice covering an extended course of treatment is acceptable, provided the notice identifies all services for which the provider believes Medicare will not pay.

If, as the course of treatment progresses, additional services are furnished for which the provider believes Medicare will not pay, the provider must separately notify the patient in writing that Medicare is not likely to pay for the additional services and obtain the beneficiary's signed statement agreeing to pay.

Complete instructions and the Advance Beneficiary Notice (ABN) forms can be found on the CMS website at the following address: http://cms.hhs.gov/BNI/

ABN Modifiers

Modifier GA should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier GY should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier GZ should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

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LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations (formerly Local Medical Review Policies) are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

California	http://www.medicarenhic.com/cal_prov/policies.shtml
New England	http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd

MEDICARE FRAUD AND ABUSE

As the CMS Part B Contractor for California, Maine, Massachusetts, New Hampshire, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

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Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Certified Nurse Mid-Wife (CNM)

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to the Benefits Integrity Safeguard Contractor.

Please direct questions concerning the CAL-BISC to:

Beth Romig, Benefit Integrity Manager
EDS - A CMS Program Safeguard Contractor
Medicare Integrity Program
P.O. Box 2806
Chico, California 95928
Phone: 1-530-896-7053
Fax: 1-530-896-7162
beth.romig@eds.com

Please direct questions concerning the NE-BISC to:

Maureen Akhouzine, Benefit Integrity Manager
New England Benefit Integrity Support Center
EDS - A CMS Program Safeguard Contractor
Medicare Integrity Program
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@eds.com

A single number to report suspected fraud is the national OIG fraud hot line: ***1-800-HHS-TIPS (1-800-447-8477).*** Information provided to hotline operators is sent out to state analysts and investigators.

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TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

Available 24 hours/day, 7 days/week (including holidays)

California	
Northern	1-877-591-1587
Southern	1-866-502-9054
New England	
Maine	1-877-567-3129
Massachusetts	1-877-567-3130
New Hampshire	1-866-539-5595
Vermont	1-866-539-5595

Provider Customer Service Directory

Hours of Operation: 8:00 a.m. to 4:00 p.m. Monday – Friday

California	
	1-877-527-6613
New England	
Maine	1-877-258-4442
Massachusetts	1-877-527-6594
New Hampshire	1-877-258-4442
Vermont	1-877-258-4442

MAILING ADDRESS DIRECTORY

Northern California

Medicare Provider Certification	P.O. Box 2812 Chico, CA 95927-2812
Medicare Preferred Provider (Assigned Claims)	P.O. Box 2804 Chico, CA 95927-2804

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Medicare Secondary Payer	P.O. Box 2004 Chico, CA 95927-2004
Medicare Secondary Payer (Cash)	P. O. Box 951 Marysville, CA 95901-951
Ambulance Claims	P.O. Box 2003 Chico, CA 95927-2003
Medicare Written Inquiries	P.O. Box 2006 Chico, CA 95927-2006
Medicare Redeterminations	P.O. Box 2800 Chico, CA 95927-2800
Medicare Fair Hearings	P.O. Box 2811 Chico, CA 95927-2811
Program Safeguard Contractor (PSC) Benefit Integrity Support Center CAL-BISC	P.O. Box 2806 Chico, CA 95927-2806
Medicare UPIN/HPSA Monitoring	P.O. Box 2805 Chico, CA 95927-2805
Medicare EDI (Electronic Data Interchange)	P.O. Box 2807 Chico, CA 95927-2807
Medicare Automatic Development System (ADS)	P.O. Box 2009 Chico, CA 95927-2009
Medicare Limiting Charge	P.O. Box 2808 Chico, CA 95927-2808
Cash Accounting	P.O. Box 391 Marysville, CA 95901-391
MSP Cash	P.O. Box 951 Marysville, CA 95901-951

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Southern California

Medicare Provider Certification	P.O. Box 2812 Chico, CA 95927-2812
Medicare Assigned Claims	P.O. Box 272852 Chico, CA 95927-2852
Medicare Non-Assigned Claims	P.O. Box 272007 Chico, CA 95927-2007
Ambulance Claims	P.O. Box 272853 Chico, CA 95927-2853
Medicare Secondary Payer (MSP)	P.O. Box 272855 Chico, CA 95927-2855
Medicare Overpayments (Recoup Checks)	P.O. Box 515301 Los Angeles, CA 90051-6601
Medicare Overpayments (Undeliverable Checks)	P.O. Box 515302 Los Angeles, CA 90051-6602
Medicare Written Inquiry	P.O. Box 272857 Chico, CA 95927-2857
Medicare Redeterminations	P.O. Box 272854 Chico, CA 95927-2854
Medicare Hearings	P.O. Box 51147 Los Angeles, CA 90051-6601
Administrative Mail ATTN: (Insert name of person)	P.O. Box 54905 Los Angeles, CA 90054-0905
Program Safeguard Contractor (PSC) Benefit Integrity Support Center CAL-BISC	P.O. Box 51447 Los Angeles, CA 90051-5747
Medicare Electronic Data Interchange (EDI)	P.O. Box 2807 Chico, CA 95927-2807

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Medicare Development Letters	P.O. Box 272859 Chico, CA 95927-2859
Undeliverable Mail	P.O. Box 54113 Los Angeles, CA 90054-0113

New England

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI	P.O. Box 9104 Hingham, MA 02044
Written Correspondence/Overpayments	P.O. Box 1000 Hingham, MA 02044
Medicare B Refunds	Medicare B Accounting Control P.O. Box 9103 Hingham, MA 02044
Medicare B Redeterminations/Hearings	P.O. Box 1000 Hingham, MA 02044
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Program Safeguard Contractor (PSC) Benefit Integrity Support Center NE-BISC	P.O. Box 8888 Hingham, MA 02044

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Durable Medical Equipment (DME)

For information, please contact the DME Regional Contractor for your area.

California Durable Medical Equipment (DME) Contractor:

Noridian Administrative Services **General Medicare Information:** 1-866-243-7272

Please view the website to find the appropriate address:
https://www.noridianmedicare.com/dme/contact/contact.html

New England Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp. **Provider Service Line:** 1-866-419-9458

Please view the website to find the appropriate address:
http://www.medicarenhic.com/dme/contacts.shtml

Reconsideration (Second Level of Appeal)

New England and California

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

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INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

http://www.medicarenhic.com

Upon entering NHIC's web address you will be first taken straight to the "homepage" where there is a menu of information. NHIC's web page is designed to be user friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:
http://visitor.constantcontact.com/email.jsp?m=1101180493704

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (CA Updates, NE Updates, EDI, etc.) will be sent out on an as needed basis.

Provider Page Menus/Links

From the home page, click onto either the **"California Providers " or "New England Providers"** link. This will take you to the "License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Scroll down to bottom of the page. Once you click "Agree", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

- Contacts
- What's New

Medicare Program
- CERT
- Enrollment
- Fraud
- Medical Review
- Policies

Provider Support
- Billing Info
- Educational Articles
- Fee Schedule
- HPSA

- LCDs
- Publications
- Specialty Info
- Updates

Resources
- CMS Links
- FAQ
- Glossary
- Related Web Sites

Education
- Education Online
- Learning Network
- MAF Meetings
- Seminars

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Medicare Coverage Database

http://www.cms.hhs.gov/center/coverage.asp
http://www.cms.hhs.gov/mcd/indexes.asp

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

http://www.cms.hhs.gov/MLNGenInfo/
The Medicare Learning Network (MLN) web site was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

http://www.cms.hhs.gov/OpenDoorForums/
CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

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

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

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto the Publications site you can access the following forms:

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)

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- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131- G, R-131-L, & 20007)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Hearing (CMS 1965)
- Medicare Managed Care Disenrollment form (CMS 566)

Other Useful Websites

Advance Beneficiary Notice (ABN)	http://cms.hhs.gov/BNI/
American Medical Association	http://www.ama-assn.org/
CMS	http://www.cms.hhs.gov http://www.medicare.gov

CMS Correct Coding Initiative
http://www.cms.hhs.gov/NationalCorrectCodInitEd/

CMS Physician's Information Resource for Medicare
http://www.cms.hhs.gov/center/physician.asp?

Evaluation and Management Documentation Guidelines
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Federal Register
http://www.archives.gov/federal-register
http://www.gpoaccess.gov/index.html

HIPAA
http://www.cms.hhs.gov/HIPAAGenInfo/

National Provider Identifier (NPI)
http://www.cms.hhs.gov/NationalProvIdentStand/

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UPIN Registry http://www.upinregistry.com

U.S. Government Printing Office http://www.gpoaccess.gov/index.html

Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1	02/2004	M. Garr	M. Kelly	Combined PA, NP, CNS guides into one.
2	4/2004	S. Kimball	B. Bedard	Revised contents
3	9/1/2004	D. Perrine	S. Kimball	Revised contents
4.0	5/9/2006	A. Randall/ S. Kimball	M. Kelly	Added summary of incident to services, revised homebound section, added split/shared services, updated Nursing Facility section
5.0	09/21/06	S Kimball and A. Randall	M. Kelly	Updated NHIC name
6.0	04-30-07	S. Kimball/S. Young	Michele Kelly	Annual Update, clarified split/shared w/in examples, added CNM guide ines and updated other sections to include CNM

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NHIC, Corp.
75 Sgt. William Terry Drive
Hingham, MA 02044

1055 West 7th Street
Los Angeles, CA 90017

620 J Street
Marysville, CA 95901

Website:
http://www.medicarenhic.com

CMS Websites
http://www.cms.hhs.gov
http://www.medicare.gov