



**Standard Paper
Remittance
Advice
Guide**

February 2010

NHIC, Corp.

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Standard Paper Remittance Advice information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as 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 Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly 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 100-04, Chapter 22 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/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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STANDARD PAPER REMITTANCE (SPR) ADVICE NOTICE

Medicare Contractors send to providers, physicians and suppliers, as a companion to claim payments, a notice of payment referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made. For each claim or line item payment, reduction, or denial, there is an associated remittance advice item. Payment for multiple claims can be reported on one transmission of the remittance advice. RA notices can be produced and transferred in either paper or electronic format. The Standard Paper Remittance (SPR) is the hard copy of an Electronic Remittance Advice. A provider may receive an RA from Medicare transmitted in an electronic format, called the **Electronic Remittance Advice (ERA)**, or in a paper format, called the **Standard Paper Remittance Advice (SPR)**. Although the information featured on the ERA and SPR is similar, the two formats are arranged differently, and the ERA offers some data and administrative efficiencies not available in an SPR.

When an SPR is received, providers may:

- Post manually to accounts receivable;
- Use it to correct any errors that may have been encountered during claims processing;
- Bill secondary health care plans that cover the beneficiary.

The RA features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments. An **adjustment** refers to any change that relates to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied Claim
- Zero Payment
- Partial Payment
- Reduced Payment
- Penalty Applied
- Additional Payment
- Supplemental Payment

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MA28	Receipt of this notice by a physician who did not accept assignment is for information only and does not make the physician a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice
MA130	Your claim contains incomplete and /or invalid information, and no appeal rights are afforded
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.

FORMAT OF SPR

Basic Sections

The paper remittance advice adheres to certain requirements to achieve a uniform look, make the most efficient use of space and have adequate area for all required data. The paper remittance advice is divided into the following sections:

- Carrier and Provider Identification Section (1)
- Bulletin Announcement Section (2)
- Claim and Detail Information Section (3)
- Totals Summary Section (4)
- Provider Adjustment Details Section (5)
- Glossary Section (6)

Carrier and Provider Identification (1)

The first page of a paper remittance advice is identified with a bolded statement, "MEDICARE REMITTANCE NOTICE" and contains complete information on the carrier and billing information for the provider, as follows:

- Medicare contractor name and complete address
- Medicare contractor Provider Call Center telephone number
- Provider's name and billing address
- Provider's National Provider Identifier (NPI)
- Number of pages included in the remittance advice
- Remittance advice date
- Check/EFT number

If a remittance advice contains multiple pages, the subsequent pages will contain abbreviated carrier and provider information, which excludes the mailing and telephone information. A duplicate notice is identified as **Medicare Duplicate Notice** in the upper right corner.

Bulletin Announcement Section (2)

Medicare related messages, reminders and other urgent and/or important information are displayed at the beginning of the paper remittance advice in an asterisk (*) segmented box.

Claim and Detail Information (3)

The remittance advice divides assigned and unassigned claim information into two separate sections. Abbreviations must be used in the claim and detail information to maximize the amount of the data that can reasonably and legibly be printed across the page. The column titles printed in the claim and detail information section are underlined. Claims are printed in the following order on the remittance advice:

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- All assigned pay claims will appear first followed by all assigned non-pay claims.
- Within the assigned pay and non-pay groupings, the claims will appear in alphabetical order by beneficiary's last name.
- Multiple claims having the same beneficiary name will appear in ICN order.

Detail Field & Descriptions

<u>PERF PROV:</u>	The performing provider number (xxxxxx).
<u>SERV DATE:</u>	Displays the service from and to dates .
<u>POS:</u>	Displays the place of service that references where the services were rendered (two digit number).
<u>NOS:</u>	Displays the units of service.
<u>PROC:</u>	Displays the HCPCS/procedure code.
<u>MODS:</u>	Displays any modifiers billed. Up to four modifiers will print.
<u>BILLED:</u>	Displays the billed amount per procedure code. (If the patient account number is reported on the claim this number will be displayed in this field after ACNT.)
<u>ALLOWED:</u>	Displays the allowed amounts per procedure code. (This amount is based on the Medicare Fee Schedule.)
<u>DEDUCT:</u>	Displays any applicable deductible amount. If the patient has already met their deductible for the year, this field will contain zero's, identifying that no deductible amount was applied to that claim.
<u>COINS:</u>	Displays the coinsurance amount. The coinsurance amount is typically 20% of the allowed amount.
<u>GRP/RC-AMT:</u>	Displays codes (Group, Reason, Remark and Offset) that are defined on the bottom or last page of the SPR. Reason and remark codes explain denials and payments. <i>Be sure to read all reason and remark codes listed for each claim, either across the top or by the line items.</i> Group codes represent who is financially liable (provider or patient). The non-covered amount will also be displayed here. These amounts will equal the difference between the billed amount and allowed amount. A total of the non-covered amount will be the last figure listed.
<u>PROV. PD:</u>	Displays the amount paid.
<u>NAME:</u>	Displays the beneficiary's name.
<u>HIC:</u>	Medicare health insurance claim number .
<u>ACNT:</u>	Patient account number.
<u>ICN:</u>	Internal Control Number (also known as ICN).
<u>ASG:</u>	This column also contains the type of assignment . A "Y" indicator shows the provider accepted assignment. An "N" indicator shows the provider did NOT accept assignment.
<u>MOA:</u>	A maximum of five Medicare outpatient adjudication (MOA) remarks code(s) per ICN are printed in the MOA field. Under the standard format, only the MOA codes approved by CMS are printed in this field.

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Adjustment (ADJS) Fields

PREV PD: Displays the amount that was previously paid.
INT: Displays the amount of interest paid on the claim. The *INT* amount is added to the *NET* amount.

LATE FILING CHARGE: Displays the amount deducted due to late filing reduction.

TRANSFERRED TO: The name of insurer whom claim is forwarded. This will also identify DME carrier or Railroad office.

NET: Displays the actual payment to provider per claim.

Summary (Totals) Fields (4)

TOTAL # OF CLAIMS: Total number of claims.
TOTAL BILLED AMT: Total amount billed.
TOTAL ALLOWED AMT: Total allowed amount. This amount is based on the Medicare Fee Schedule.
TOTAL DEDUCT AMT: Total amount of the deductible applied.
TOTAL COINS AMT: Total amount of coinsurance if applicable.
TOTAL RC-AMT: Total amount of non-covered services. This is the difference between the total billed amount and the total allowed amount.
TOTAL PROV PD AMT: Total amount paid. This should be the check amount if no adjustments are made.
TOTAL PROV ADJ AMT: Total amount adjusted.
TOTAL CHECK AMT: Total amount of check. This field will always display 0.00 on Duplicate Notices.

Provider ADJ (Adjustment) Section (5)

PLB REASON CODE: Displays Reason codes for any adjustments including interest paid, late filing reductions, offset amounts withheld from claims. Reason codes are defined in the glossary at the bottom of the SPR.
FCN: Displays the internal claim number (ICN) involved in an offset.
HIC: Displays the health insurance claim number involved in an offset.
AMOUNT: Displays the amount involved in an offset.

Group Code Definition

- PR** Patient responsibility. This signifies the amount that may be billed to the beneficiary or to another payer on the beneficiary's behalf. For example, PR would be used with the reason code for patient deductible or coinsurance or if the patient assumed financial responsibility for a service not considered reasonable and necessary, or for the cost of therapy or psychiatric services after the coverage limit had been reached.
- CO** Contractual obligations. This includes any amount for which the provider is financially liable, such as participation agreement violations, late filing penalties, and limiting charge violations. Patients may not be billed for these amounts.
- OA** Other adjustment. This would be used if neither PR or CO applies, such as with a reason code message that indicates that the bill is being paid in full (e.g., reason code 92).
- CR** Correction or reversal of a prior decision. This group code applies whenever there is a change to a previously adjudicated claim. CR explains the reason for the correction; PR, CO and/or OA must always be used in tandem with CR to show the revised information

Glossary Section (6)

The remark and/or reason code appears in the detail Claim Detail Information Section of the remittance advice. The associated message description printed in the Glossary Section to facilitate interpretation.

Codes and related message descriptions are printed in the following order:

- A. Group codes - A group code will be entered with all reason/remark codes to establish financial liability, indicating when you may or may not bill a beneficiary for the non-paid balance of the service you rendered.
- B. Reason codes
- C. Line level remark codes
- D. Claim level remark codes/MOA - Medicare MOA remark codes are used to convey appeal information and other claim specific information that does not involve a financial adjustment. An appropriate appeal, Limitation of Liability or other message must be used whenever applicable.
- E. Claim and detail level remark codes
- F. Adjustment codes

REMITTANCE ADVICE CODES AND MESSAGES

CMS is the national maintainer of the remittance advice remark code list. The remark code list is available at www.wpc-edi.com/codes/. The list is updated three times a year: March, July and November. Remark codes are used to relay service-specific Medicare informational messages that cannot be expressed with a reason code.

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Reason codes and the text messages that define those codes are used to explain why a claim may not have been paid in full. For instance, there are reason codes to indicate that a particular service is never covered by Medicare, that a benefit maximum has been reached, to identify non-payable charges which exceed the fee schedule or a psychiatric reduction. Reason codes are used with an ANSI group code to explain how the claim was processed.

Claims where another payer is primary to Medicare show patient and provider liability at the line level to enable the provider to know the reason for any denial or reduction on individual services and to allow the provider to know how much liability remains after offset by the primary payment. The standard paper remittance advices are designed to allow a provider to balance the amount of the payments and the adjustments for each line item against the amount billed for that line item. All adjustments that apply are shown for each line, including each case when the amount of a patient's and/or provider's liability is satisfied by a primary payer and the amount credited from a primary payer's combined payment toward each line item. When apportioning a primary's payment toward the amounts for which a beneficiary or provider is liable, the payment is apportioned in the following hierarchy:

- 1 Beneficiary deductible
- 2 Beneficiary coinsurance
Any other amount for which the beneficiary is liable as signified by a **PR** (patient responsibility) group code
- 3 Any amount for which a provider is liable as shown with **CO** (provider liability) group code
- 4 Any amount shown with an **OA** (Other Adjustment) group code except for OA-100. This amount will be combined with OA-23, which signifies the primary payer's reimbursement amount.

In addition, the primary's payment only offsets the provider's liability to the extent that the primary's allowed amount is higher than the Medicare allowed amount. A 'CO-23' (Medicare Secondary Payer liability met) adjustment is not made if the primary's allowed amount is less than the Medicare allowed amount.

PSYCHIATRIC REDUCTION CLAIMS

Amounts on the MSN and the remittance advice must agree. To this end, psychiatric payment reductions are calculated and rounded at the line level, not the claim level. In addition, a psychiatric reduction is always expressed with ANSI X12 835 reason code 122. A psychiatric reduction is never listed as an otherwise non-covered charge or the claim may be rejected by the patient's supplemental insurer.

NATIONAL CORRECT CODING INITIATIVE

The 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

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, 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. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) 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.

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations 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:

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/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, 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.

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 Safeguard Services (SGS).

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If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

New England:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.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.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversied Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

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

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m.- Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m.- Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission

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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
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:
www.medicarenhic.com

Durable Medical Equipment (DME)

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)

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

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 "home page" 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 (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", 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.

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) website 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/>

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)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

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?>

Electronic Prescribing

<http://www.cms.hhs.gov/erxincentive/>

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Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

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/>

NPI Registry

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.hhs.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

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

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	August 2004	M. Kelly	B. Bedard	New guide
2.0	8/26/05	B. Bedard	M. Kelly	Clarified & updated sections
3.0	06/18/09	B. Bedard	M. Clark	Annual Review updated addresses and numbers
4.0	02/04/10	B. Bedard	Mylene Clark	Annual Review , no changes

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