

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



Official CMS Information for
Medicare Fee-For-Service Providers

MLN GUIDED PATHWAYS TO MEDICARE RESOURCES



MLN GUIDED PATHWAYS TO MEDICARE RESOURCES
Intermediate Curriculum for Health Care Providers

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INTRODUCTION TO MLN GUIDED PATHWAYS

It is recommended that you study the “MLN Guided Pathways to Medicare Resources: Basic Curriculum for Health Care Professionals, Suppliers, and Providers” prior to commencing review of this intermediate-level guide. This resource was created by the Medicare Learning Network® (MLN), the official Centers for Medicare & Medicaid Services (CMS) source for Fee-For-Service (FFS) provider information. Always available in the banner of the CMS website is the Outreach and Education tab, which houses the MLN. The MLN is the brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information.

The basic curriculum provides a fundamental overview of Medicare knowledge, whereas this intermediate curriculum focuses on detailed Medicare policies and requirements for providers who enroll in Medicare using the CMS-855A enrollment application or the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Providers searching for information on Medicare preventive services can find it consolidated into the basic curriculum. There is a companion guide entitled “MLN Guided Pathways to Medicare Resources: Intermediate Curriculum for Health Care Professionals and Suppliers” for those physicians, non-physician practitioners, and suppliers who enroll using the CMS-855B, CMS-855I, or CMS-855S enrollment applications.

After reviewing the intermediate-level guide, move on to “MLN Guided Pathways Provider Specific,” which includes specialty and facility specific information for Medicare institutional providers, physicians, health care professionals, and suppliers.

We generally anticipate most individuals will not read these resources line-by-line in their entirety but rather will select topics of interest to them.

Use the clickable bookmarks to the left or the clickable Table of Contents on the previous page to view specific sections of this intermediate curriculum.

MEDICARE INSTITUTIONAL PROVIDER REQUIREMENTS

ENROLLMENT AND SURVEY/CERTIFICATION

IOM – “Medicare General Information, Eligibility and Entitlement Manual,” Pub. 100-01, Chapters 2 and 5

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 2 “Hospital Insurance and Supplementary Medical Insurance” includes information about Medicare Part A entitlement and eligibility. Chapter 5, “Medicare General Information, Eligibility, and Entitlement,” provides definitions of terms. It also includes information about provider agreements, which include specific provider commitments.



FAST FACT: Provider Agreements

Certain providers sign provider agreements, which require the providers to comply with regulations. Therefore, new provider agreements are not made when regulations change.

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

<http://www.cms.gov/manuals/downloads/clm104c01.pdf>

Chapter 1, “General Billing Requirements,” provides information on provider assignment to Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs). This chapter also includes information about provider agreements.

IOM – “Medicare Program Integrity Manual,” Pub 100-08, Chapter 10 and 15

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 10, “Medicare Provider/Supplier Enrollment,” provides information on the application and enrollment processes for becoming a Medicare provider/supplier. Chapter 15, “Medicare Enrollment,” provides information on specific services provided by Medicare providers/suppliers and enrollment applications used by those entities.



FAST FACT: Enrollment Fee

Providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, or
- A request for a hardship exception to the application fee.

Brochure – “Medicare Enrollment for Institutional Providers”

<http://www.cms.gov/MedicareProviderSupEnroll/downloads/providers.pdf>

This brochure offers an overview of the enrollment process for institutional providers.

Fact Sheet – “The Basics of Medicare Enrollment for Institutional Providers”

http://www.cms.gov/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf

This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure institutional providers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

Form – Medicare Enrollment Application – Institutional Providers Form CMS-855A

<http://www.cms.gov/cmsforms/downloads/cms855a.pdf>

This is a link for the CMS-855A, the Medicare enrollment application for institutional providers.

Survey/Certification/Accreditation

IOM – “State Operations Manual,” Pub. 100-07, Chapters 1 and 2

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 1, “Program Background and Responsibilities,” explains the background and responsibilities of State Agency activities regarding Medicare providers. Chapter 2, “The Certification Process,” describes the certification process and includes information about enrollment, provider-based designation, and change in ownership.

Web Page – Certification & Compliance

<http://www.cms.gov/CertificationandCompliance>

This web page provides an overview of certification and compliance requirements for Medicare.

Web Page – Survey & Certification

http://www.cms.gov/SurveyCertificationGenInfo/01_Overview.asp

This web page covers the role of CMS to maintain oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers, including hospitals, nursing homes, Home Health Agencies (HHAs), End-Stage Renal Disease (ESRD) facilities, hospices, and other facilities serving Medicare beneficiaries.



FAST FACT: Survey

The survey process is used to determine if a provider meets the requirements for participation in the Medicare Program. Failure to contact the State Survey Agency (SA) or a Medicare-approved accreditation organization in a timely manner may delay enrollment into the Medicare Program. Certification from the SA or an accreditation organization must be received before enrollment can be completed.

Web Page – Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)

http://www.cms.gov/CFCsAndCoPs/01_Overview.asp

CMS develops CfCs and CoPs that providers must meet in order to begin and continue participating in the Medicare and Medicaid Programs. This web page provides links to information about these conditions by provider type.

Web Page – Accreditation

http://www.cms.gov/SurveyCertificationGenInfo/07_Accreditation.asp

This web page provides information on national Accreditation Organizations (AOs) including a list of CMS-approved organizations.



FAST FACT: Accreditation

The law permits providers accredited by an approved national (AO) to be exempt from routine surveys by State Survey Agencies to determine compliance with Medicare conditions. Accreditation by an AO is voluntary and is not required for Medicare certification. Providers who may be accredited include:

- Hospitals,
- Critical Access Hospitals (CAH),
- Inpatient Psychiatric Hospitals (IPF),
- Home Health Agencies (HHA),
- Hospices,
- Outpatient Physical Therapy (OPT) / Other Rehabilitation Facilities (ORF), and
- Outpatient Speech Pathology Facilities (OSP).

BILLING

Billing Submission

IOM – “Claims Processing Manual,” Pub. 100-04, Chapters 1, 2, 24, and 25

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 1, “General Billing Requirements,” includes information such as verification of benefits, prepayment prohibitions, billing for noncovered charges, adjustments, and frequency of billing. Chapter 2, “Admission and Registration Requirements,” focuses on admission and also includes information about prohibition of prepayment. Chapter 24, “General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims,” includes Electronic Data Processing (EDI) and Coordination of Benefits (COB) information and Chapter 25, “Completing and Processing the Form CMS-1450 Data Set,” is about the Form CMS-1450 (UB-04).



FAST FACT: Claims Processing Manual

In addition to the Internet-Only Manual (IOM) Publication 100-04 (Pub. 100-04) chapters listed in this intermediate pathway, there are many provider-specific chapters.

Web Page – Institutional Paper Claim Form (CMS-1450)

http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp

This web page provides information on the Form CMS-1450 (UB-04) used by institutional providers.

Billing Submission



FAST FACT: UB-04, Form CMS-1450, or the 837 Institutional Electronic Format

With limited exceptions, providers are required to submit initial claims electronically using the 837 Institutional format. The National Uniform Billing Committee (NUBC) is responsible for the design and printing of the UB-04, otherwise known as the Form CMS-1450.

Website – National Uniform Billing Committee

<http://www.nubc.org/become.html>

Codes used for Medicare claims are available to paid subscribers from the National Uniform Billing Committee (NUBC) via the NUBC's "Official UB-04 Data Specifications Manual."



FAST FACT: Billing Codes

Billing codes such as Revenue and Occurrence Codes are available from Medicare Fee-For-Service A/B MACs. Codes are also available from the NUBC <http://www.nubc.org/index.html> via the NUBC's "Official UB-04 Data Specifications Manual."

Fact Sheet – "UB-04 Overview"

http://www.cms.gov/MLNProducts/downloads/ub04_fact_sheet.pdf

This fact sheet is designed to provide education on the UB-04 paper claim form, which is only accepted from institutional providers who are excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk.

Web-Based Training Course – Uniform Billing (UB-04)

http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp

This web-based training course is designed to provide education for Medicare-participating institutional providers on the requirements for hard-copy and electronic billing. It includes important information about the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims, including ASCA exceptions and ASCA Unusual Circumstance Waivers. In addition to a step-by-step explanation of UB-04 form fields, this training also includes a list of important external resources. To access the course, scroll down to the Web-Based Training (WBT) Courses.

Ordering/Referring Physician/Non-physician Practitioner

IOM – "Medicare Program Integrity Manual," Pub. 100-08, Chapter 14

<http://www.cms.gov/manuals/downloads/pim83c14.pdf>

Chapter 14, entitled "National Provider Identifier," outlines the requirement for a National Provider Identifier (NPI) on a paper or electronically submitted Medicare claim to identify an ordering/referring/attending/operating/supervising/purchased service/other/service facility provider (in the X12N 837 claims transactions) or prescriber (in the NCPDP 5.1 retail drug claim transaction).

Ordering/Referring Physician/Non-physician Practitioner



FAST FACT: Ordering Services

If a billed item or service requires an ordering/referring physician NPI and this information is not on the claim, the claim will not be paid. Instructions for finding the Viewing Individual Practitioner Status and Specialty Type in Internet-based PECOS are available under the Downloads section at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website.

Notifications to Beneficiaries

IOM – “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 1, 30, and 33

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 1, “General Billing Requirements,” has several references to Advance Beneficiary Notices (ABNs) and provides examples of their use. Chapter 30, “Financial Liability Protections,” includes information about Limitations on Liability and ABNs as well as other Financial Liability Protections (FLPs) under the law. Chapter 33, “Miscellaneous Hold Harmless Provisions,” addresses Medicare Fee-For-Service hold harmless provisions that are not included elsewhere in the IOM.



FAST FACT: Beneficiary Notices Initiative (BNI)

In addition to Advance Beneficiary Notices of Noncoverage (ABNs), various institutional providers have other types of required notices, some of which must be expedited. Refer to http://www.cms.gov/BNI/01_overview.asp on the CMS website.

Web Page – Statutory Guidance

http://www.cms.gov/BNI/14_Statutory%20Guidance.asp

This web page outlines applicable laws related to FLPs which can be found in Title 18 (XVIII) of the Social Security Act and in Title 42 of the Code of Federal Regulations.

Part A Inpatient Benefit Periods

IOM – “Medicare General Information, Eligibility, and Entitlement Manual,”

Pub. 100-01, Chapter 3

<http://www.cms.gov/manuals/downloads/ge101c03.pdf>

Chapter 3, “Deductibles, Coinsurance Amounts, and Payment Limitations,” provides information on benefit periods as well as deductibles, coinsurance amounts, and payment limitations for hospital insurance (Part A).

Part A Inpatient Benefit Periods



FAST FACT: Benefit Periods

A benefit period is a period of time for measuring the use of hospital insurance benefits (Part A). It is a period of consecutive days during which covered services furnished to a beneficiary, up to certain specified maximum amounts, may be paid for by Part A.

Physician/ Non-physician Practitioner Certification of Services

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

<http://www.cms.gov/manuals/downloads/ge101c04.pdf>

Chapter 4, “Physician Certification and Recertification of Services,” covers information on physician certification requirements for services provided in the institutional setting.



FAST FACT: Physician Certification

Certain services must be certified by a physician or non-physician practitioner, when appropriate.

Tools

Educational Tool – Medicare Learning Network® Suite of Products and Resources for Inpatient Hospitals

http://www.cms.gov/MLNEdWebGuide/45_MLN_Suite_of_Products_and_Resources_for_Inpatient_Hospitals.asp

This suite of products provides Medicare Part A providers with an understanding of the various PPS rates and classification criterion for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals and skilled nursing facilities. It also provides Part A business office management professionals with accurate, timely and easy-to-understand billing and coding products as well as information to assist in understanding and streamlining claims submissions.

CODING

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

<http://www.cms.gov/manuals/downloads/clm104c12.pdf>

Chapter 12, “Physicians/Nonphysician Practitioners,” provides information on the correct coding policy, which applies to some outpatient institutional services.

Web Page – National Correct Coding Initiatives (NCCI) Edits

<http://www.cms.gov/NationalCorrectCodInitEd>

This web page provides information to providers on Medicare's NCCI edits. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. A subset of NCCI edits is incorporated into the Outpatient Code Editor (OCE) for Outpatient Prospective Payment System (OPPS) and therapy provided by Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Physical Therapy (OPT), Speech-Language Pathology (SLP) providers, and Home Health Agencies (HHAs). This web page provides a link to the "NCCI Policy Manual for Medicare Services," as well as links to download the most current NCCI code sets.



FAST FACT: "NCCI Policy Manual for Medicare Services"

In this manual, many policies are described utilizing the term physician. Unless indicated differently, the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes. CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries since these denials are based on incorrect coding rather than medical necessity.

REIMBURSEMENT

Institutional Reimbursement

IOM – "Medicare Claims Processing Manual," Pub. 100-04, Chapters 1 and 33

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 1, "General Billing Requirements," describes policy applicable to Medicare Fee-For-Service claims, or what is known as the original or traditional Medicare Program. Information in this chapter includes information on jurisdiction for claims, termination of provider agreements, filing a request for payment, provider billing of noncovered charges, time limitations for filing claims, and filing adjustments and late charges. Chapter 33, "Miscellaneous Hold Harmless Provisions," provides information on hold harmless provisions.



FAST FACT: Inpatient/Outpatient

An inpatient is a person who has been admitted to a facility for bed occupancy for purposes of receiving inpatient services. An outpatient is a person who has not been admitted but is registered with the facility as an outpatient and receives services from the provider.

IOM – "Medicare Financial Management Manual," Pub. 100-06, Chapters 9 and 12

<http://www.cms.gov/Manuals/IOM/list.asp>

Chapter 9, "Provider Statistical & Reimbursement Report," explains the Provider Statistical and Reimbursement (PS&R) System. Chapter 12, "Instructions for Medicare Credit Balance Report Activities," provides instructions for Medicare credit balance report activities.

Institutional Reimbursement

Paper Manual – “The Provider Reimbursement Manual,” Part 1 and Part 2

<http://www.cms.gov/Manuals/PBM/list.asp>

Paper-based manuals are CMS manuals that were officially released in hardcopy. The majority of these manuals were transferred into the IOM or retired from the manual. Pub. 15-1 and Pub. 15-2 are exceptions to this rule and are still active paper-based manuals. The remaining paper-based manuals are for reference purposes only. “The Provider Reimbursement Manual” provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended. These Principles of Reimbursement for Provider Costs have been published in HIRM-I. The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations.

Web Page – Medically Unlikely Edits

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

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. This web page links to the Facility Outpatient, Practitioner Services, and DME Supplier Services MUE tables.

Web Page – Cost Reports

http://www.cms.gov/CostReports/01_Overview.asp

This web page includes links to provider-specific cost report information.



FAST FACT: Cost Reports

Medicare-certified institutional providers are required to submit an annual cost report to their Fee-For-Service A/B MAC. The exception to this requirement applies to Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs) where 100% of the services rendered are reimbursed on a fee schedule basis. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data.

Web Page – Prospective Payment Systems (PPS)

<http://www.cms.gov/ProspMedicareFeeSvcPmtGen>

CMS uses separate PPS systems for reimbursement to acute inpatient hospitals, Home Health Agencies (HHAs), hospice, hospital outpatient, Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and SNFs. This web page links to information about each of these.



FAST FACT: PPS Reimbursement

PPS is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

Institutional Reimbursement

Web Page – Provider Statistical & Reimbursement (PS&R) Report

<http://www.cms.gov/PSRR>

This web page includes information about the PS&R including a link to a provider page on the left.



FAST FACT: Provider Statistical & Reimbursement (PS&R) System

This is a CMS system that accumulates and reports Medicare Part A claims data into categories needed for Medicare cost reporting. Providers utilize PS&R reports to accumulate statistical and payment data to prepare their Medicare cost reports, and FIs and MACs use this data to settle the cost reports.

Non-CMS Organizations with Input Regarding Reimbursement

Web Page – MedPAC

<http://www.medpac.gov>

This web page provides information on the Medicare Payment Advisory Commission (MedPAC), which is an independent Federal body advising Congress on Medicare issues.

Web Page – Provider Reimbursement Review Board (PRRB)

<http://www.cms.gov/PRRBReview>

This web page provides basic information on the Provider Reimbursement Review Board (PRRB). The PRRB is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination made on its cost report.

Remittance Advice (RA)

Web Page – Health Care Payment and Remittance Advice

http://www.cms.gov/ElectronicBillingEDITrans/11_Remittance.asp

This web page includes information about the Electronic Remit Advice (ERA) and Standard Paper Remit (SPR).



FAST FACT: Remittance Advice (RA)

Current version 4010 and 4010A1 implementation guides for the ASC X12 835 electronic standard are available at <http://www.wpc-edi.com/content/view/533/377> on the Internet.

The next HIPAA standard is known as version 5010. The 5010 implementation guides (also known as Technical Reports Type 3 or TR3s) are available at <http://www.x12.org> on the Internet.

Remittance Advice (RA)

Web Page – Claim Adjustment Reason Codes and Remark Codes

<http://www.wpc-edi.com/content/view/180/223>

CMS has national responsibility for maintenance of the remittance advice remark codes. Requests for new or changed remark codes are submitted to CMS via this Washington Publishing Company web page.

Web-Based Training – Understanding the Remittance Advice for Institutional Providers

http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp

This web-based training course is designed to provide education for institutional providers and their billing staff on general Remittance Advice (RA) information. This training includes instructions for interpreting and reconciling the RA received from Medicare. It also provides guidance for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittances in addition to an overview of the free software Medicare provides for viewing ERAs. To access the course, scroll down to the Web-Based Training (WBT) Courses.



FAST FACT: Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes

CARCs and Remittance Advice Remark Codes are used to explain adjustments at the claim or service line level. Provider Level Adjustment or PLB Reason Codes are used to explain any adjustment at the provider level.

QUALITY



FAST FACT: Public Information

The various quality initiatives touch every aspect of the health care system. Some initiatives focus on publicly reporting quality measures for nursing homes, Home Health Agencies (HHAs), hospitals, and kidney dialysis facilities. Consumers can use the quality measures information that is available on <http://www.medicare.gov> for these health care settings to assist them in making health care choices or decisions.

OTHER MEDICARE INFORMATION

Clinical Trials

IOM – “Medicare National Coverage Determinations Manual,” Pub. 100-03, Chapter 1, Part 4

http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

Part 4 discusses routine costs and the qualification process for clinical trials.

Clinical Trials

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

<http://www.cms.gov/manuals/downloads/clm104c30.pdf>

Chapter 30, “Financial Liability Protections,” addresses specific language to be used in an Advance Beneficiary Notice of Noncoverage (ABN) when there is no Medicare coverage of clinical trials.

Web Page – Medicare Clinical Trial Policies

<http://www.cms.gov/ClinicalTrialPolicies>

This web page provides an overview on clinical trials and how they are researched and designed to evaluate the safety and effectiveness of medical care.



FAST FACT: Clinical Trials

Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types and informing payers about what services to cover.

Medicare Program Rates & Statistics

Web Page – Medicare Program Rates & Statistics

<http://www.cms.gov/MedicareProgramRatesStats>

This web page provides information on the operations of Medicare, Medicaid, and the health care industry including a brief summary of the Medicare and Medicaid Programs including information on benefits and financing, health care indicators, market basket indices for health care providers, and the average Medicare trust fund interest rates.

Telehealth

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

<http://www.cms.gov/manuals/Downloads/bp102c15.pdf>

Chapter 15, “Covered Medical and Other Health Services,” discusses telehealth services for Medicare.

Web Page – Telehealth

<http://www.cms.gov/Telehealth>

This web page provides an overview of telehealth services.



This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network[®] (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://www.cms.gov/MLNProducts> and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

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