

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 Professionals and Suppliers**

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**MLN GUIDED PATHWAYS TO MEDICARE RESOURCES**  
**Intermediate Curriculum for Health Care Professionals and Suppliers**

## **INTRODUCTION TO MLN GUIDED PATHWAYS**

It is recommended that the learner 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 those physicians, non-physician practitioners, and suppliers who enroll in Medicare using the CMS-855B, CMS-855I, CMS-855O, or CMS-855S enrollment applications or the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Physicians, non-physician practitioners, and suppliers 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 Providers” for those institutional providers who enroll using the CMS-855A enrollment application.

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.

This information is directed at the following health care professionals and suppliers who bill carriers or A/B Medicare Administrative Contractors (MACs):

Physicians enrolling on the 855I (individual) or 855B (clinic or group practice):

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Chiropractic (with respect to certain specified treatment)
- Doctor of Dental Surgery or Dental Medicine (within the limitations of the law)
- Doctor of Optometry (within the limitations of the law)
- Doctor of Podiatric Medicine (within the limitations of the law)

Other practitioners enrolling on the 855I:

- Anesthesiology Assistant
- Audiologist
- Clinical Psychologist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Clinical Social Worker
- Mass Immunization Roster Biller (individual practitioner)
- Nurse Practitioner
- Occupational Therapist in private practice
- Physical Therapist in private practice
- Physician Assistant
- Psychologist billing independently
- Qualified Anesthetist
- Registered Dietitian or Nutrition Professional
- Speech-Language Pathologist in private practice

Suppliers enrolling on the 855B:

- Ambulance Service Suppliers
- Ambulatory Surgical Center
- Clinics/Group Practices (Hospital Departments, Multi-Specialty Clinics, Physical/Occupational Therapy Group in Private Practice, Public Health/Welfare Agency, Single Specialty Clinic)
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Mammography Center
- Mass Immunization Roster Biller (groups)
- Portable X-ray Supplier
- Radiation Therapy Center
- Slide Preparation Facility

Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS) that bill DME MACs enroll on the 855S.

In addition, this information is helpful to institutional providers who bill Part B services to the Fiscal Intermediary (FI) or A/B MAC or to hospitals that may bill for Medicare Part B practitioner services.

## MEDICARE PHYSICIAN, OTHER HEALTH CARE PROFESSIONAL OR SUPPLIER REQUIREMENTS

### **IOM – “Medicare General Information, Eligibility, and Entitlement Manual,” Pub. 100-01, Chapters 1 and 5**

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

Chapter 1 of this manual, “General Overview,” includes an explanation of the obligations of being a Medicare provider of services. Chapter 5 of this manual is entitled “Definitions” and includes definitions of the various types of Medicare physicians, practitioners, and suppliers, as well as the various agreements entered into by those providers.

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

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

Chapter 15 of this manual is entitled “Covered Medical and Other Health Services” and outlines Medicare coverage of specific types of services. It also defines physician and practitioner.

### **IOM – “Medicare Program Integrity Manual,” Pub. 100-08, Chapter 10**

<http://www.cms.gov/manuals/downloads/pim83c10.pdf>

Chapter 10 of this manual, “Medicare Provider/Supplier Enrollment,” specifies the resources and procedures Medicare Fee-For-Service (FFS) MACs must use to establish and maintain physician, non-physician practitioner, and supplier enrollment in the Medicare Program.

### **FAST FACT: Internet-Only Manuals (IOMs)**

Many points of interest are in the Centers for Medicare & Medicaid Services (CMS) Manual System, called the Internet-Only Manuals (IOMs). Access the publications that comprise the IOM at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. Pub. refers to one of the manuals (publications) in the CMS IOM, such as Pub. 100-08, “Medicare Program Integrity Manual.” To edit/search for a term, click on a chapter within a manual.

### **Web Page – Practice Administration Center**

<http://www.cms.gov/center/practice.asp>

This web page for practice administration includes links to billing/payment, enrollment, policies and regulations, quality initiatives, education, Medicare Fee-For-Service Part B drugs, Medicare prescription drug coverage, the Medicare Modernization Act, and Medicare Secondary Payer (MSP) information. Scroll down to browse by special topics which includes a Newsroom Center with information on health care reform and legislative issues.

### **Web-Based Training – Your Office in the World of Medicare**

[http://www.cms.gov/MLNProducts/03\\_WebBasedTraining.asp](http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp)

This web-based training course is designed to provide education on the fundamentals of the Medicare Program. It includes information about Parts A, B, C and D; beneficiary health insurance options, eligibility, enrollment, and how Medigap and Medicaid work with the Medicare Program. The MLN offers a series of WBTs to teach the fundamentals of Medicare. This course is second in the series and should be taken after The World of Medicare. To access the course, scroll down to the Web-Based Training (WBT) Courses.

## BILLING

### **IOM – “Medicare Claims Processing Manual,” Pub. 100-01, Chapter 30**

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

Chapter 30, “Financial Liability Protections,” includes information explaining the Financial Liability Protections (FLP) provisions that protect beneficiaries, physicians, non-physician practitioners, and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay.

### **IOM – “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 1, 12, and 32**

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

Chapter 1 of this manual is entitled “General Billing Requirements” and includes fundamental information such as timely filing, jurisdictions where to file claims, mandatory assignment, participating and nonparticipating providers, limiting charge, and collecting beneficiary insurance information. It also contains information on reassignment of benefits, reciprocal and locum tenens billing arrangements, billing for non-covered services and information on billing for anti-markup tests (other than clinical lab). Chapter 12, “Physicians/Nonphysician Practitioners,” includes information about Medicare billing policies for various services, such as telephone, telehealth, concurrent care, evaluation and management, home visits, prolonged visits, standby, face-to-face exam prior to ordering power mobility vehicles, team/telephone calls for case management, care of beneficiaries in facilities/institutions, and very unusual travel. Chapter 32 is entitled “Billing Requirements for Special Services” and provides billing instructions for a range of specific Medicare services.



### **FAST FACT: Part B Billing and Reimbursement**

The “Medicare Claims Processing Manual” at <http://www.cms.gov/manuals/iom/list.asp> includes information on Part B billing and reimbursement. For example, chapter 13 describes billing and payment for radiology services. Chapter 16 outlines billing and payment under the laboratory fee schedule. Chapter 17 provides a description of billing and payment for drugs and biologicals. Chapter 18 describes billing and payment for preventive and screening services.



### **FAST FACT: Professional Provider Telecommunications Network (PPTN)**

The PPTN is a service offered by Medicare FFS MACs to those who submit Medicare claims electronically. PPTN provides quick and easy access to information such as Medicare beneficiary eligibility, claim status, summary of claims volume, summary of payments, pricing information, and diagnosis and procedure code lookups. Physicians, non-physician practitioners, and suppliers in the PPTN have the capability to dial directly into the Multi-Carrier System (MCS) to receive information on their claims that are being or have been processed.

### Web-Based Training – CMS Form 1500

[http://www.cms.gov/MLNProducts/03\\_WebBasedTraining.asp](http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp)

This web-based training course is designed to provide information that will allow providers to file Medicare Part B claims accurately. It includes information and directions for billing that will help to reduce or eliminate the chances of receiving unprocessable rejections. To access the course, scroll down to the Web-Based Training (WBT) Courses.

### Fact Sheet – “Form CMS-1500 At A Glance”

[http://www.cms.gov/MLNProducts/downloads/form\\_cms-1500\\_fact\\_sheet.pdf](http://www.cms.gov/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf)

This fact sheet is designed to provide education on the Form CMS-1500, which is the standard paper claim form used by health care professionals to bill for Medicare Part B services. It includes background information and a descriptive crosswalk of files in the paper versus the electronic form.



## FAST FACT: Additional Information Available in Provider Specific Pathways

Refer to the “MLN Guided Pathways Provider Specific” pathways for more detailed information on specific physician, non-physician practitioner, and supplier guidelines.

### Transcript – Referring/Ordering Physician Required to Supply National Provider Identifier (NPI)

<http://www.cms.gov/EducationMaterials/Downloads/NationalProviderIdentifierRoundtable.pdf>

This transcript of a National Provider Identifier (NPI) teleconference includes important information on use of the NPI.

## CODING

### Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCS) Coding

#### IOM – “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 12 and 23

<http://www.cms.gov/manuals/iom/list.asp>

Chapter 12, “Physicians/Nonphysician Practitioners,” provides correct coding policy for various services. Chapter 23, “Fee Schedule Administration and Coding Requirements,” includes International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM), Health Care Common Procedure Coding System (HCPCS), and Current Procedural Terminology (CPT) coding requirements. It also includes instructions for codes with modifiers.

#### Web Page – DMEPOS Coding

<http://www.dmepdac.com>

Visit the Pricing, Data Analysis, and Coding (PDAC) contractor web page for guidance to manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS), the codes by which Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services are identified on Medicare billing. The web page also includes information on Medicare pricing, data analysis, and coding.

## Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCS) Coding

### Web Page – National Correct Coding Initiative (NCCI) Edits

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

The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. Links on the left of this web page allow users to search for improper coding combinations by code section. The “National Correct Coding Initiative Coding Policy Manual for Medicare Services,” divided by CPT code, is available with coding requirements.

### Article – Modifier – 59

<http://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>

This article explains the importance of the correct use of modifier - 59.

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## REIMBURSEMENT AND COVERAGE

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

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

Chapter 4 of this manual is entitled “Physician Certification and Recertification of Services” and outlines requirements for physician certification of DMEPOS supplies and services such as home health, hospice, and outpatient physical therapy, occupational therapy, and speech-language pathology.



### FAST FACT: Certification

Physician certification is required for Medicare Part A to cover services provided by institutions such as hospitals, Skilled Nursing Facilities (SNFs), outpatient therapy providers, Home Health Agencies (HHAs), and hospices. Without physician certification of these services, they will not be covered by Medicare. Certain Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) also require physician certification. Nurse Practitioners (NPs) may certify Part A outpatient therapy and SNF services. Medicare also allows certain Non-physician Practitioners (NPPs) to certify DMEPOS.

### 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,” outlines the eligibility criteria and conditions of payment for telehealth services.

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

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

Chapter 12, “Physicians/Nonphysician Practitioners,” provides claims processing instructions for physician and non-physician practitioner services, most of which are paid according to the Medicare Physician Fee Schedule (MPFS). This chapter also explains services/supplies that are covered under Medicare that have Health Care Procedure Coding System (HCPCS) codes, but paid in bundled payment with other related services.

### **Web-Based Training – Understanding the Remittance Advice for Professional Providers**

[http://www.cms.gov/MLNProducts/03\\_WebBasedTraining.asp](http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp)

This web-based training course is designed to provide education for professional 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.

### **Brochure – “Medicare Remit Easy Print (MREP) Software”**

[http://www.cms.gov/MLNProducts/downloads/MedicareRemit\\_0408.pdf](http://www.cms.gov/MLNProducts/downloads/MedicareRemit_0408.pdf)

This brochure is designed to provide information about Medicare Remit Easy Print (MREP) software, which enables physicians and suppliers to view and print their remittance information. Topics include MREP basics, the benefits of using electronic remittance information, minimum system requirements, and related resources available on the Internet.



### **FAST FACT: Itemized Statement**

Section 4311(b) of the Balanced Budget Act of 1997 gave beneficiaries the right to submit a written request for an itemized statement from their physician, non-physician practitioner, or supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of \$100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the MAC to review specific issues (i.e., services not provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

## **QUALITY**

### **IOM – “Quality Improvement Organization Manual,” Pub. 100-10**

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

This manual includes responsibilities, eligibility, and other activities related to Quality Improvement Organizations (QIOs).



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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