Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

May 2002

Dear State Program Integrity Director:

The Medicaid Alliance for Program Safeguards hosted a focus group meeting in October 2001. Present at the meeting were Medicaid representatives from 17 States, senior managers from CMS, a representative from APHSA, as well as other managers and staff from the Centers for Medicare and Medicaid Services (CMS).

The focus groups' principal purpose was to identify obstacles to effective and efficient Medicaid-Medicare program integrity coordination, particularly data sharing, and to propose achievable solutions. One specific area identified was the need to develop basic materials for State program integrity staff to acquire a better working knowledge of Medicare program operations.

As a result of the meeting, we developed the attached "Introduction to Medicare Operations" resource document. The material will provide you and your staff with information about the various Medicare programs, including key contacts to obtain additional information. We hope you will find this resource document, including its numerous reference aids, an essential tool in your staff's fraud and abuse efforts.

These materials are another step in our continued efforts to strengthen the ties between the Medicare and Medicaid programs which, when combined, account for over $402.7 billion in Federal and State expenditures in fiscal year 2001.

To assist us in future initiatives, we invite you to provide us feedback about this document. Please send any comments or suggestions to Lisa Zone at mailto:lzone@cms.hhs.gov (410) 786-5995 or Janis Craig, at mailto:jcraig@cms.hhs.gov (410) 786-9268.

Sincerely,

/s/
Rose Crum-Johnson, Administrator
Southern Consortium
CMS

/s/
Timothy Hill
Director
Program Integrity Group
CMS

Enclosure

INTRODUCTION TO MEDICARE OPERATIONS

Medicaid State Agency Guide to Medicare Operations

May 2002

Introduction to Medicare Operations

PREFACE

Over the past several years the Centers for Medicare & Medicaid Services (CMS) have attempted to strengthen the working relationship between the Medicare and Medicaid programs. In October 2001, a group of Federal and State executives met to discuss various strategies to accomplish this task. Several items were identified to further this goal, including the need to develop basic materials for State program integrity staff to acquire a better working knowledge of Medicare program operations. Attached is a compendium of materials entitled **Introduction to Medicare Operations,** which we hope will become an invaluable information resource. This material is but one of several initiatives designed to assist the States in completing their critical work of ensuring the integrity of the Medicaid program.

CMS, formerly the Health Care Financing Administration, administers the Medicare program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPPA) standards. In addition, CMS assures the health and safety of beneficiaries served by providers participating in the Medicare and Medicaid programs (survey and certification) and the accuracy of clinical laboratory services. The enclosed materials provide basic information about various aspects and activities of the Medicare program, and include key contacts to obtain additional information. We hope that this resource document, which includes numerous reference aids, will become an essential tool in preventing fraud and abuse.

Introduction to Medicare Operations

Acknowledgements

This product is the result of a collaboration between the Medicare Program and the Medicaid Alliance for Program Safeguards.

Prepared by:

Medicare Program Integrity Group

- **Bill Gould**
- **Lisa Zone**

Medicaid Alliance for Program Safeguards

- **Paul Miner**
- **Janis Craig**

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

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OVERVIEW OF MEDICARE

Introduction
The purpose of this document is to introduce the Medicare program. Medicare is separated into three parts -Part A, Part B and Part C. This section describes the different types of beneficiaries eligible for Medicare Parts A, B and C and the various types of Medicare coverage your patients may be eligible for. A portion of this section is dedicated to explaining how the different branches of the Federal government affect the policies/payments of Medicare Parts A, B and C.

Common terms and Medicare acronyms appearing in this document will be explained in detail and include:
Common Terms:

- Medicare Part A
- Medicare Part B
- Medicare Part C
- Contractor
- Fiscal Intermediary
- Carrier
- Beneficiary

Medicare Acronyms:

- CMS - Center for Medicare & Medicaid Services
- CLIA -Clinical Laboratory Improvement Amendments
- EMC -Electronic Media Claims
- E/M -Evaluation and Management
- HIC -Health Insurance Claim Number
- CPT -Current Procedural Terminology
- HCPCS -CMS Common Procedure Coding System
- ICD-9-CM -International Classification of Diseases
- MSP -Medicare Secondary Payer
- OCR -Optical Character Recognition
- UPIN -Unique Physician Identification Number
- RRB -Railroad Retirement Board

What is Medicare?
Medicare is a federal health insurance program which provides medical coverage for people 65 or older, for certain disabled people, and for some people with end-stage renal disease (ESRD). The program, which began July 1,1966, was established by Congress through Title XVIII of the Federal Social Security Act. Medicare is managed by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), which is a branch of the Health and Human Services (HHS) division of the U.S. Federal government. CMS awards contracts to organizations called contractors to process claims for Medicare and perform related administrative functions (e.g., claims processing). CMS provides operational direction and policy guidance for nationwide administration of the program.

How Big Is The Medicare Program?

In 1999, Medicare:

- processed more than 700 million claims;
- paid out more than $77 billion in benefits; and

- had 39 million beneficiaries receiving benefits.

What Is Medicare Part A?

Part A of the Medicare program is hospital insurance. This part of the program is financed by:

- taxes paid by employers and employees through the Federal Insurance Contributions Act (FICA);
- self-employed individual contributions through the Self-Employment Contributions Act; and
- railroad workers, their employers and representatives through the Railroad Retirement Act.

Organizations which administer Medicare Part A are called "fiscal intermediaries "(FI).

Part A coverage helps to pay for (not limited to):

- inpatient hospital care;
- inpatient care in a skilled nursing facility following a covered hospital stay;
- home health care; and
- hospice care.

What Is Medicare Part B?

Part B of the Medicare program is medical insurance.
Financing for this part of the program is obtained from:

- premium payments by enrollees;
- occasional contributions from general revenues by the Federal government; and
- interest earned on the Part B trust fund.

Organizations which administer Medicare Part B are called "carriers."

Part B coverage helps to pay for (not limited to):

- medically necessary doctors 'services provided in a variety of medical settings including, but not limited to, the physician's office, an inpatient/outpatient hospital setting, rural health clinics and ambulatory surgical centers;
- charges from limited licensed practitioners such as: independently practicing physical/occupational therapists, licensed clinical social workers and clinical psychologists, certified registered nurse anesthetists, nurse midwives, advanced registered nurse practitioners (ARNPs); physician's assistants (PAs); and audiologists;
- clinical laboratory and diagnostic services;
- surgical supplies and durable medical equipment; and
- ambulance services.

What Is Medicare Part C?

A Medicare beneficiary may choose to have covered items and services furnished to him/her through a managed care plan instead of the traditional Medicare Program. This coverage, referred to as "Medicare+Choice" or "Medicare Part C "is a new set of health care options created by the Balanced Budget Act of 1997.This new option allows the Medicare beneficiaries more choices in health care and the contractors that serve them. Examples of Medicare+Choice providers include:

- Health Maintenance Organizations (HMO);

- Point of Service (POS)Option;
  - Provider Sponsored Organization (PSO);
- Preferred Provider Organization (PPO);
- Medicare Medical Savings Account (MSA);
- Private Fee-For-Service Plan; or
- A Religious Fraternal Benefit Society Plan (RFP).

The Medicare Managed Care Plan must have a contract with the Secretary of Health and Human Services (HHS) in order to participate in the Medicare program as a Medicare Managed Care Plan. A Medicare Managed Care Plan must provide the same services, which a beneficiary would be eligible to receive from Medicare if he/she was not a Managed Care Plan enrollee. In other words, the beneficiary is still technically "on Medicare ", but has selected a different contractor and is required to receive services according to that contractor's arrangements. The beneficiary's entitlement to Medicare is based on the same criteria whether his/her health care expenses are payable by an HMO or traditional Medicare carriers and/or fiscal intermediaries. Medicare beneficiaries will be able to enroll or disenroll from a Medicare Managed Care Plan*at any time through the year 2001; however, beginning January 1, 2002 limits will be placed on when disenrollment can occur.

*The only exception is Medicare Medical Savings Accounts (MSA), for which he/she is "locked in "for a period of one year.

Who Is Eligible For Medicare?

There are three basic types of individuals who are eligible to be insured by Medicare. One becomes eligible based on one 's own earnings, or on those of a spouse, parent, or child. A specified number of quarters of coverage (QCs) must be earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA). The exact number of QCs required for insured status depends on to which of the three basic groups the individual belongs:

- the aged;
- the disabled; or
- those with end-stage renal disease.

The effective date of Medicare Part B and Part C coverage depends on the month in which enrollment takes place therefore, the effective dates for Medicare Part A, Part B or Part C may be different.

Medicare Part B is a voluntary program for which the insured must pay a monthly premium. Eligibility requirements have been established that must be met before the beneficiary would not be required to pay a monthly premium for Medicare Part A coverage (also known as premium-free HI). If the requirements for premium-free HI are not met, but the beneficiary is still eligible for Medicare and he/she wishes to have coverage under Medicare Part A, he/she must pay a monthly premium. It is estimated that less than 1%of current Medicare beneficiaries are paying a monthly premium for Medicare Part A coverage.

Some individuals are eligible for Medicare Railroad Retirement Benefits. The Railroad Retirement Board (RRB) will issue the Medicare card to individuals eligible for those benefits.

Medicare Fee-for-Service Contractors: Entities Perform Different Functions

Contractor Type	Function	Limitations/ Special Provisions	Selection Mechanism
Fiscal Intermediary **See Intermediary-Carrier Directory, Appendix A**	A health insurance company that is nominated by a group or association of providers of health care services to make payments for covered Medicare services.	Must be nominated by a group or association of providers of health care services	For Blue Cross plans, Blue Cross and Blue Shield Association subcontracts to local Blue plan with CMS approval. For commercial insurer, providers nominate.
Carrier	A health insurance company that is selected (by competition or designation) by CMS to make payment to physicians and other practitioners for covered Medicare services.	Must be a health insurance company. By definition, a fiscal intermediary performs certain carrier functions.	CMS may select carrier by competitive process or by designation.
Durable Medical Equipment Regional Carrier	A health insurance company that is selected (by competition or designation) by CMS to make payment to durable medical equipment suppliers.	Must be a health insurance company. Regions defined by regulation.	CMS may select carrier by competitive process or by designation.
Regional Home Health Intermediary	A fiscal intermediary designated by CMS to make payment for covered Medicare services to home health agencies and hospices.	Must be a fiscal intermediary. Provider nomination does not apply.	CMS works with BCBSA to identify replacement from among current Blue plans.

Legislative Authority - Fiscal Intermediaries and Carriers

Fiscal Intermediaries

• **Section 1816** of the Social Security Act authorizes the use of fiscal intermediaries to make Medicare payments to institutional providers of health care services, such as hospitals and nursing facilities.
– This section entitles providers to "nominate" the entity to serve as their Medicare fiscal intermediary.
– The Secretary is not bound to accept all nominations, but has no authority to contract outside the nomination process.
– In 1966, the American Hospital Association nominated BCBSA to be the prime fiscal intermediary contractor -- an arrangement that continues today.

Carriers

• **Section 1842** of the Social Security Act authorizes HHS to enter into contracts with carriers to make Medicare payments to physicians, and ambulance companies and other suppliers.
– This section requires that entities serving as carriers have experience administering health insurance plans; that is, carriers must be health insurers.
• **Section 1834** provides further authority to HHS to contract with regional carriers for the processing of claims for durable medical equipment, prosthetics, orthotics and supplies.

Medicare Fee-For-Service Contractors Current Environment - Overview

- As of the end of FY 2001, there are a total of 36 companies which hold contracts to process Medicare fee- for-service claims.
- Because several companies administer both Parts A and B, there are currently 29 fiscal intermediaries and 20 carriers processing Medicare fee-for-service claims.
- Twenty- seven of the fiscal intermediaries are Blue Cross Plans, including the Blue Cross and Blue Shield Association as the prime Blue contractor.
- Two of the fiscal intermediaries, Mutual of Omaha and Cooperative, are commercial insurance companies.
- Four fiscal intermediaries serve as Regional Home Health Intermediaries (RHHIs).
- There will be only 28 fiscal intermediaries effective November 1, 2001, when North Carolina BCBS ends its service.
- Fifteen of the carriers are Blue Shield plans.
- Five of the carriers (Wisconsin Physician Services, CIGNA, National Heritage Insurance Company, Nationwide, and Group Health Incorporated) are commercial insurance companies.
- Four carriers also serve as Durable Medical Equipment Regional Carriers (DMERCs).

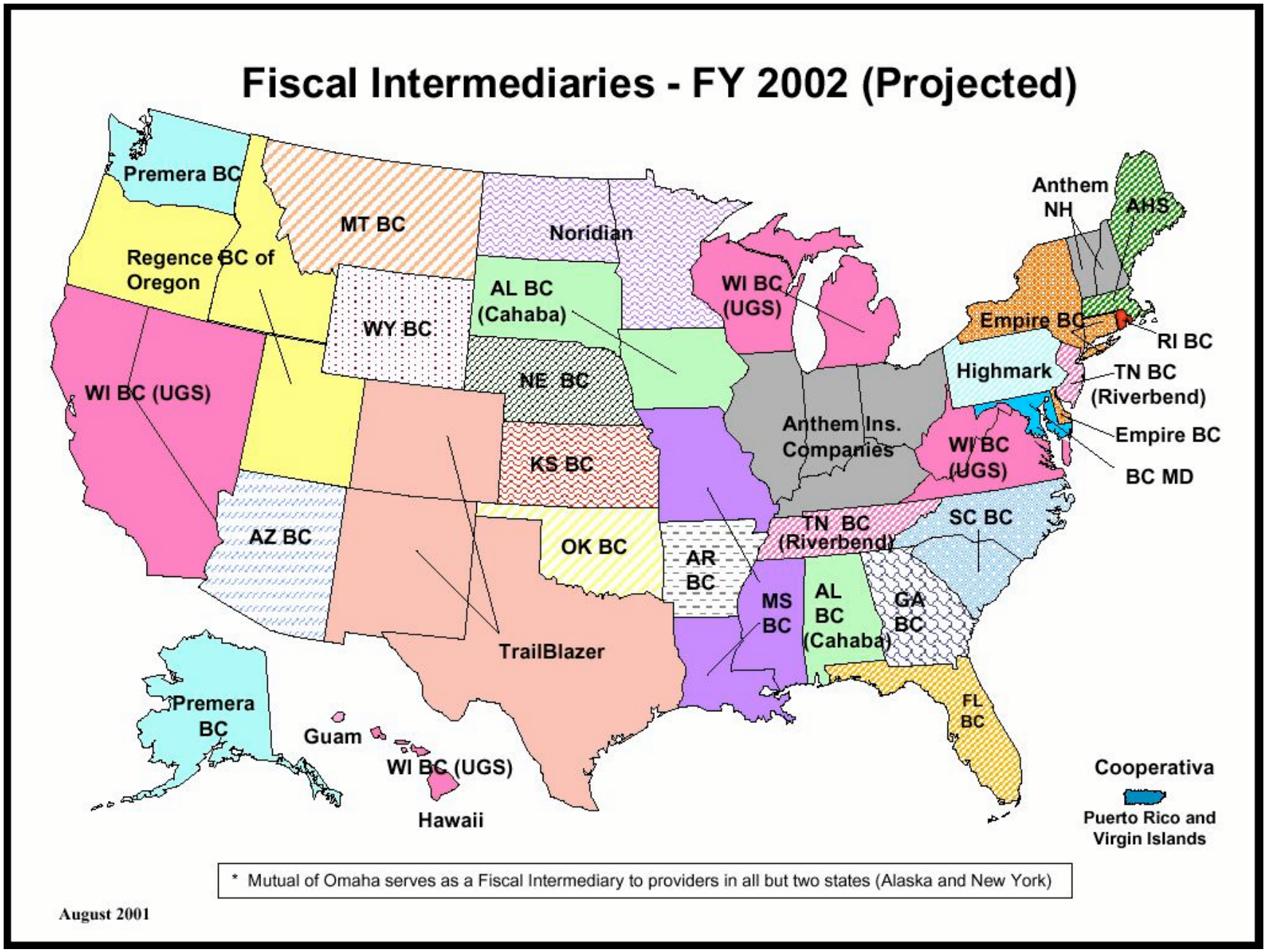
Medicare Fee-for-Service Contractors: Statistics at a Glance

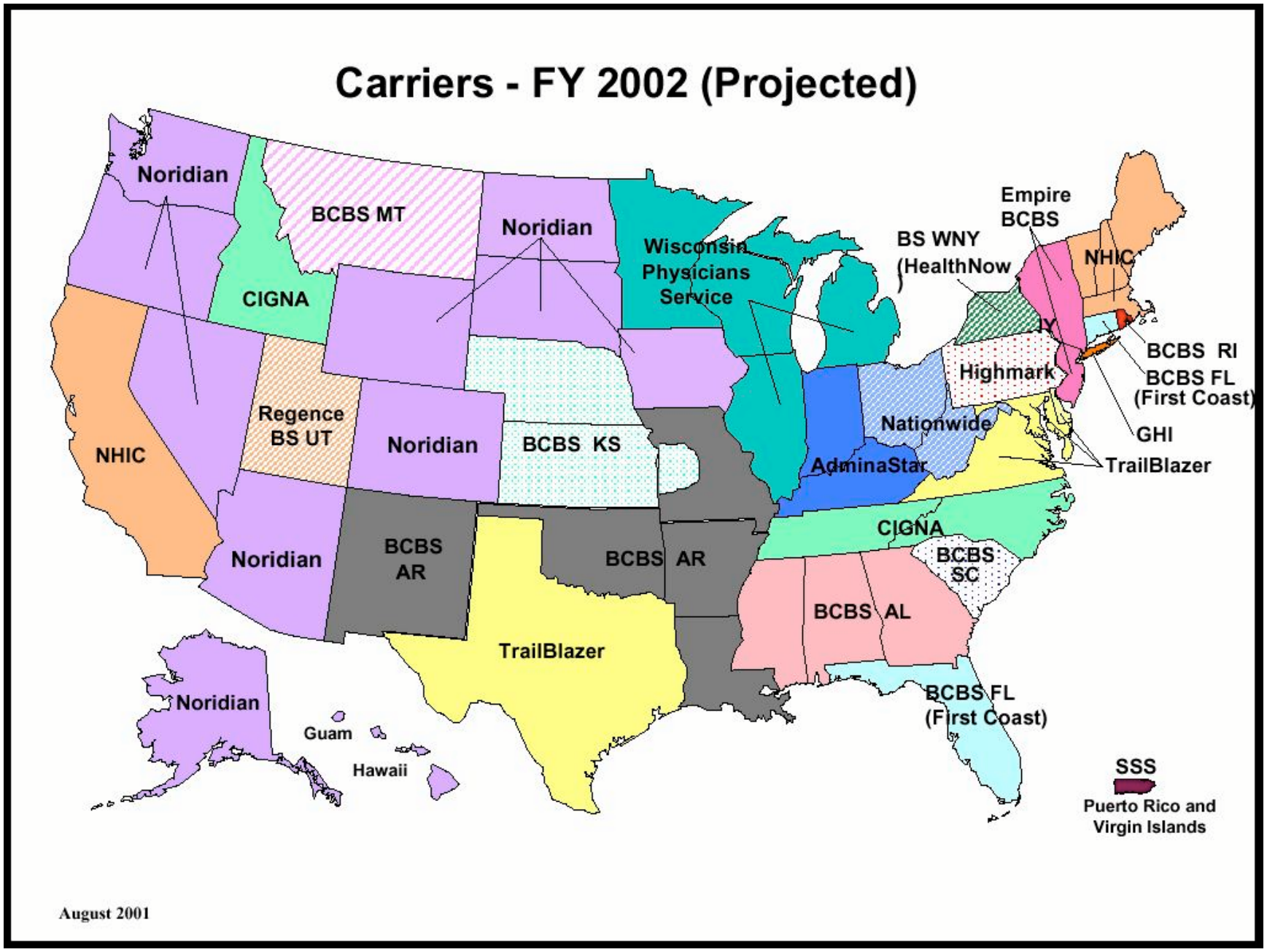
In FY 2001, the Medicare claims processing contractors will -

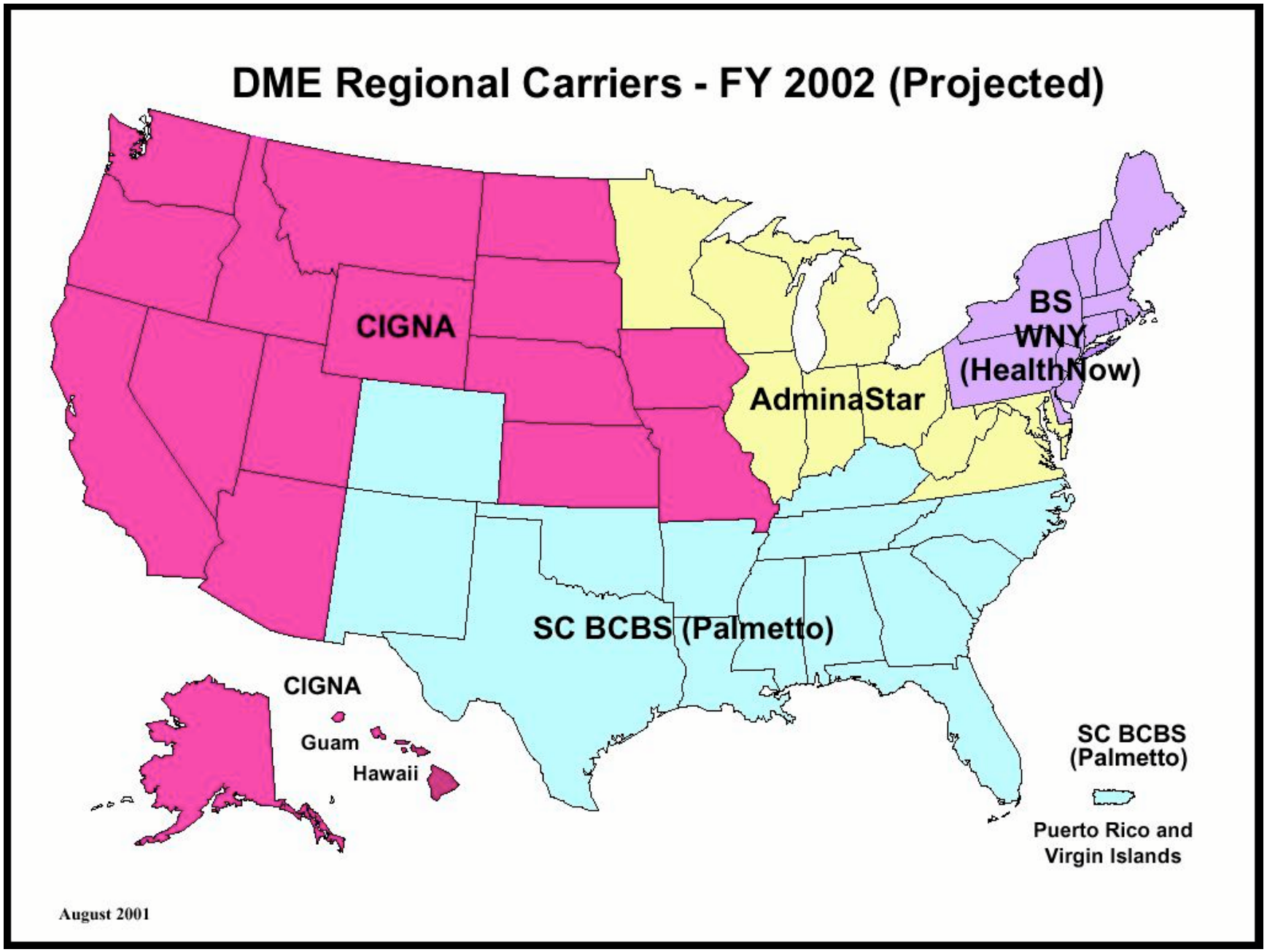
- Provide claims processing and customer services to about 33 million beneficiaries
- Work with approximately 1. 1 million health care providers
- Process between 915 and 930 million Medicare claims
- Pay out between $175 and $200 billion for beneficiary health care services
- Handle more than 7 million review requests and other kinds of appeals

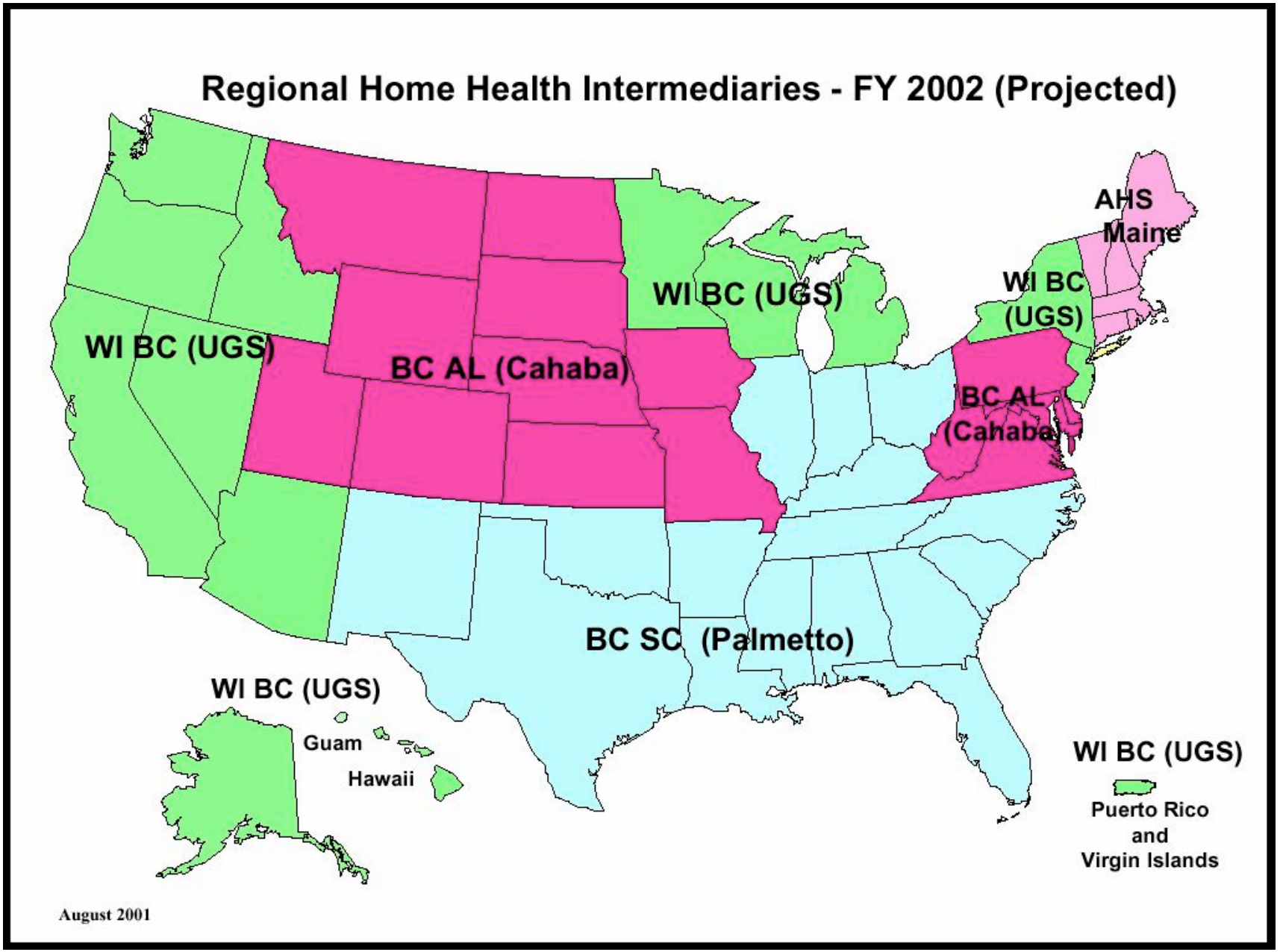
NOTE: The majority of claims are submitted electronically

- *Part A - 97. 4%*
- *Part B - 81. 9%*


Fiscal Intermediaries - FY 2002 (Projected)
Premera BC
MT BC
Noridian
Regence BC of Oregon
AL BC (Cahaba)
WI BC (UGS)
WY BC
NE BC
WI BC (UGS)
KS BC
Anthem Ins. Companies
Anthem NH
AHS
Empire BC
RI BC
Highmark
TN BC (Riverbend)
Empire BC
BC MD
WI BC (UGS)
SC BC
TN BC (Riverbend)
AZ BC
OK BC
AR BC
MS BC
AL BC (Cahaba)
GA BC
FL BC
TrailBlazer
Premera BC
Guam
WI BC (UGS)
Hawaii
Cooperativa
Puerto Rico and Virgin Islands
* Mutual of Omaha serves as a Fiscal Intermediary to providers in all but two states (Alaska and New York)
August 2001


Carriers - FY 2002 (Projected)
Noridian
BCBS MT
Noridian
Wisconsin Physicians Service
Empire BCBS
BS WNY (HealthNow
NHIC
CIGNA
NY
BCBS RI
BCBS FL (First Coast)
Highmark
Regence BS UT
Noridian
BCBS KS
Nationwide
GHI
NHIC
AdminaStar
TrailBlazer
CIGNA
Noridian
BCBS AR
BCBS AR
BCBS SC
BCBS AL
TrailBlazer
Noridian
Guam
Hawaii
BCBS FL (First Coast)
SSS
Puerto Rico and Virgin Islands
August 2001


DME Regional Carriers - FY 2002 (Projected)
CIGNA
AdminaStar
BS
WNY
(HealthNow)
SC BCBS (Palmetto)
CIGNA
Guam
Hawaii
SC BCBS
(Palmetto)
Puerto Rico and
Virgin Islands
August 2001


Regional Home Health Intermediaries - FY 2002 (Projected)
AHS
Maine
WI BC (UGS)
WI BC
(UGS)
WI BC (UGS)
BC AL (Cahaba)
BC AL
(Cahaba)
BC SC (Palmetto)
WI BC (UGS)
Guam
Hawaii
WI BC (UGS)
Puerto Rico
and
Virgin Islands
August 2001

OVERVIEW - PROGRAM SAFEGUARD CONTRACTORS (PSCs)

The Medicare Integrity Program (MIP), which was created under the Health Insurance Portability and Accountability Act of 1996, enacted new authorities which allow CMS to contract with entities beyond, but also including, our current Medicare Carriers and Fiscal Intermediaries (FIs) to perform specific program safeguard functions.

Using its authority under MIP, CMS awarded contracts to 12 prime Program Safeguard Contractors (PSCs) in May 1999.

(1) Aspen Systems Corporation, Inc.
(2) Blue Cross Blue Shield of Alabama
(3) Computer Sciences Corporation (CSC)
(4) California Medical Review, Inc.
(5) DynCorp.
(6) Electronic Data Systems Corp. (EDS)
(7) Lifecare Management Partners, Inc.
(8) Reliance Safeguard Solutions, Inc.
(9) Science Applications Intl. Corp. (SAIC)
(10) TriCenturion, LLC
(11) United Government Services
(12) Mutual of Omaha

NOTE: For more information about the PSCs, including information regarding PSC contacts and sub-contracting opportunities, please refer to our web site at **www.hcfa.gov**.

Now that CMS has established these 12 PSCs on a list of eligible and able contractors, we can issue, compete, evaluate, and award individual task orders among the PSCs. These task orders are for some, all, or any sub-set of the work associated with the following payment safeguard functions: medical review, cost report audit, data analysis, provider education and fraud detection and prevention.

Establishing this list of eligible PSC contractors allows CMS great flexibility. First, we have ensured that capable contractors are available to undertake the work. Secondly, we have created a pool of contractors who can become experienced in program safeguard functions so that we can turn to them when special needs or program vulnerabilities arise.

Current PSC Task Orders

To date we have awarded the following task orders to the PSCs.

(1) **Perform Millennium-Related National Data Analysis and Provider On-Site Reviews:** Under this task order Computer Sciences Corporation conducted national data analysis to minimize the potential risk of increased fraud and abuse during the millennium critical months.

The PSC then conducted Coordinated Comprehensive Provider Reviews, on an as needed basis, on providers determined to be a potential fraud risk.

Awardee: Computer Sciences Corporation (CSC)
GTL: Deb Lewis, Denver RO
Co-GTL: Michelle Lombardo, PI
Completion Date: June 2002

(2) **Establish a Part A Benefit Integrity Support Center (BISC) in New England:** This task order focuses on performing data analysis and fraud unit activities in New England. In the fall 2001 this task order was modified to enable the BISC to assume the benefit integrity workload of National Heritage Insurance Company, Anthem New Hampshire Vermont, and Blue Cross Blue Shield of Rhode Island.

Awardee: Electronic Data Systems (EDS)
GTL: Phil Coyne, Boston RO

(3) Conduct On-Site Community Mental Health Center (CMHC) Reviews: The purpose of this project is for qualified mental health professionals to conduct uniform, professional and unannounced visits to CMHCs. These site visits will serve as a tool for screening applicants and enrollees in the Medicare program. This task order was modified to also include site-visits to Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs).

Awardee: California Medical Review, Inc. (CMRI)
GTL: Jim Ralls, PI
Completion Date: March 30, 2002

(4) Review Providers for Compliance with Office of the Inspector General (OIG)Corporate Integrity Agreements (CIAs): Under this task order, the PSCs performs on-site reviews of providers that are subject to CIAs as part of a settlement with the OIG. The PSC reviews the providers' CIA obligations and conducts a statistically valid random sample of claims to ascertain if the provider is meeting all of their CIA commitments.
Awardee: TriCenturion, LLC
GTL: John Martino, Philadelphia RO
Co-GTL: Maureen Savory, PI
Completion Date: February 15, 2002

(5) Develop a Nationally Focused Medicare Integrity Provider Education Plan: The PSC is conducting a national education needs assessment and developing a comprehensive Medicare Integrity Program educational plan. The needs assessment involves surveying our current contractors, providers, and medical and professional groups. The task order was modified to

include development of training materials, including specialty-specific vignettes, for Evaluation and Management (E/M) Documentation Guidelines.

Awardee: Aspen Systems Corporation
GTL: Brenda Thew, PI
Co-GTL for E&M Vignette Development: Latesha Walker, CMM

(6) **Conduct Home Office Cost Report Audits of Large Chain Facilities:** This task order supplemented the efforts of Medicare Fiscal Intermediaries by conducting three field audits on Home Office Chains. All of the work under this task order was completed in March 2001.

Three Awardees: United Government Services (UGS), Aspen Systems Corporation, and Science Applications International Corporation (SAIC)
GTL: Jerry Mulcahy, FSG
Co-GTL: Jack Nixon, Seattle RO
Completion Date: March 2001

(7) **Statistical Analysis Center:** The Statistical Analysis Center (SAC) performs a wide variety of statistical data analysis and trending activities on Medicare claims data and related information. These activities are performed to support focused medical review, medical policy development and early detection of potential fraud and abuse. For now, the PSC conducts their data analysis activities for beneficiaries residing in Minnesota, Wisconsin and Michigan.

Awardee: DynCorp.
GTL: Dave Gardner, BAG
Co-GTL: Mike McElliott, Chicago RO
Completion Date: March 2002

(8) **Comprehensive Error Rate Testing Program:** The Comprehensive Error Rate Testing (CERT) program will produce national, contractor specific, benefit category specific and provider specific paid claim error rates. The program calls for independent reviewers to periodically review a systematic random sample of paid and denied claims. Paid claims are medically reviewed and denied claims are validated by the independent reviewers to ensure that the decision was appropriate. The decisions of the independent reviewers will be entered into a tracking database and used to produce annual error rates.

Awardee: DynCorp.
GTL: Thel Moore & Kevin YoungWayne, PI
Co-GTL: Libby Rasbury, San Francisco RO

(9) **Systems Requirements:** Under this task order we have asked the four primary systems maintainers, who are also PSCs or sub-contractors to PSCs, to first develop the work-around plans necessary to implement a full PSC with no systems changes. We have also asked that

these entities assess and prepare the systems requirements documents necessary to implement the modifications required to implement a fully integrated PSC from a systems perspective.

Three Awardees: Computer Sciences Corporation (CSC) for the Common Working File and Durable Medical Equipment Systems, TriCenturion for the Part A Standard System, and Electronic Data Systems (EDS) for the Part B Standard System.
GTL: Phil Kauzlarich, PI
Completion Date: October 2001

(10) **Nebulizer Project:** Under this task order, the Program Safeguard Contractor (PSC) supported the nebulizer drug review project sponsored by CMS and the Office of the Inspector General (OIG). The tri-State review, conducted in Florida, Texas and Louisiana, focused on the group of procedure codes collectively referred to as "Policy Group-Nebulizers & Related Drugs." The PSC supported this project by conducting medical review and participating in the State Project Teams that conduct field investigations and on-site reviews. The work under this task order was completed in the spring of 2001.

Awardee: LifeCare
GTL: Jackie Proctor, Atlanta RO
Completion Date: May 31, 2001

(11) **Western Integrity Center:** The Western Integrity Center (WIC) supports CMS's program integrity efforts by undertaking specific program integrity functions, including post-payment medical review, fraud detection and deterrence, and data analysis, for Medicare Carrier claims submitted in the States of Washington, Alaska, Oregon, Nevada, Arizona, Hawaii, North Dakota, South Dakota, Wyoming, Colorado, and Iowa and for Fiscal Intermediary claims submitted in the States of North Dakota and Minnesota. The WIC assumed these post-payment program integrity functions from Noridian, the Medicare Carrier and Fiscal Intermediary in the above mentioned states. The WIC and Noridian work collaboratively as defined in their Joint Operating Agreement.

Awardee: Computer Sciences Corporation (CSC)
GTL: Michelle Lombardo, PI
Co-GTL: Hedy Wong, Seattle RO

(12) **Region A - Durable Medical Equipment (DME) PSC:** This task order created a Region A (Northeast) DME PSC that performs all pre and post-payment program integrity related activities. Blue Cross Blue Shield of Western New York, doing business as HealthNow NY, is the replacement contractor for the United Health Care Durable Medical Equipment Regional Carrier (DMERC) workload. All of the DMERC workload, including all program integrity activities, was transitioned from United Health Care to HealthNow NY on September 30, 2000. Then, over the course of one year, September 30, 2000 to September 30, 2001, the PSC and HealthNow NY worked collaboratively to smoothly transition all PSC functions to the

PSC. TriCenturion was fully operational as the Region A DMERC PSC effective October 1, 2001.

Awardee: TriCenturion, LLC
GTL: Mike Crochunis, PI
Co-GTL: Scott Greer, Philadelphia RO

(13) **Therapy Service PSC:** The Therapy Service PSC supports CMS's program integrity efforts by performing data collection and statistical analysis related to therapy services, developing an error rate, providing information required by a Report to Congress, establishing review protocol and a plan for reviewing therapy services provided in all settings, and developing educational and outreach materials.

Awardee: DynCorp.
GTL: Dorothy Shannon, PI
Co-GTL: Sue Fleck, Boston RO
Completion Date: February 15, 2002

(14) **Correct Coding Initiative:** The Correct Coding Initiative PSC maintains and develops edits that are used by Medicare Fiscal Intermediaries and Carriers in their claims processing operations.

Awardee: Reliance Safeguard Solutions
GTL: Kim Downin, PI

(15) **Medicare Managed Care Payment Validation:** The purpose of this task order is to (1) analyze data from Medicare +Choice rate cell payments for persons in special status and validate the accuracy of payments; (2) identify potential program integrity vulnerabilities as a result of data analysis; and, (3) provide recommendations for solutions to identified program vulnerabilities, including strengthening the HCFA payment validation approval process.

Awardee: California Medical Review, Inc. (CMRI)
GTL: Scott Nelson, CHPP
Co-GTL: Linda Territo, Dallas RO

(16) **North Carolina PSC:** In August 2001 Blue Cross Blue Shield of North Carolina announced that they were leaving the Medicare program. CMS simultaneously competed North Carolina's workload to a replacement Fiscal Intermediary, Palmetto, and to a PSC, Blue Cross Blue Shield of Alabama. The PSC transitioned the post-payment program integrity workload from North Carolina effective October 1, 2001.

Awardee: Blue Cross Blue Shield of Alabama
GTL: Kathy Uram, PI

Co-GTLs: Jerry Mulcahy, FSG
Joy Morrison, Atlanta RO

(17) **Data Assessment and Verification (DAVE) PSC:** The DAVE PSC supports CMS's efforts by providing an ongoing centralized data surveillance process to assess the accuracy and reliability of CMS data particular to the health care provided by nursing facilities and home health agencies, and payment for these services. The findings shall produce evidence for further actions at national, regional and State levels in addressing concerns in the areas of program integrity, beneficiary health and safety, and quality improvement.

Awardee: Computer Sciences Corporation (CSC)
GTL: Jill Nicolaisen, PI
Co-GTL: Heidi Gelzer, CMSO

(18) **Ohio/West Virginia PSC:** Nationwide, the Medicare Carrier for the states of Ohio and West Virginia, announced their intent to leave the Medicare program on November 8, 2001. On December 27, 2001 CMS awarded a contract to DynCorp. to assume the post-payment medical review and benefit integrity activities previously performed by Nationwide. Palmetto GBA will be the replacement Carrier. All work will be transitioned from Nationwide to Palmetto and the PSC no later than June 30, 2002.

Awardee: DynCorp.
GTL: Maureen Savory, PI
Co-GTL: Mike McElliott, Chicago RO

Next Steps - PSC Implementation Strategy

Background:

- In 1996 Congress enacted the Medicare Integrity Program (MIP) to give the Centers for Medicare & Medicaid Services (CMS) the authority to contract with other than, but not excluding, Medicare Carriers and Fiscal Intermediaries (FIs) to perform certain program safeguard functions.

- In accordance with MIP, in May 1999 CMS awarded contracts to twelve Program Safeguard Contractors (PSCs) to perform certain program safeguard functions.

- Since 1999, CMS has awarded task orders for eighteen different projects to the PSCs and has tested a number of different ways to configure PSC work.

PSC Implementation Strategy:

- We have tested and evaluated a number of different PSC operational models. Now, based on our analysis of the strengths, weakness, opportunities and risks of these PSC models, we are ready to move from a testing and evaluation phase to an implementation phase.

- CMS has designed an Implementation Strategy that achieves two primary CMS objectives:

- Promoting competition and allowing market forces to foster innovation and accountability; and,

- Focusing resources on true problem providers; while still providing the vast majority of honest providers with the education, information and assistance they need to bill the program appropriately.

What Work Will be Transitioned from the Medicare Carriers and FIs to the PSCs?

- Our experience has taught us that we need to proceed with a PSC operational model that has clear lines of accountability and defined roles, responsibilities and goals for both the PSCs and the Medicare Carriers and FIs.

- From a program safeguard perspective, CMS has two primary goals that will drive the base work performed by the PSCs and the Medicare Carriers and FIs - reducing fraud and abuse in the Medicare program and reducing the fee-for-service claims payment error rate.

- We have decided to allocate work between the PSCs and the Carriers and FIs according to these two goals. The PSCs will be accountable for reducing fraud and abuse in the Medicare program; and, the Medicare Carriers and FIs will be responsible for reducing the Medicare fee-for-service claims payment error rate.

- We believe that the PSCs and the Medicare Carriers and FIs are the right contractors to do this work. Fraud and abuse detection and prevention will be the PSCs sole objective. They have the data tools and capabilities necessary to uncover new program vulnerabilities and the professional expertise to investigate potential fraud and abuse cases. Additionally, the Medicare Carriers and FIs are uniquely positioned to perform the outreach, education and claims review necessary to reduce the error rate.

- Both the PSCs and the Medicare Carriers and FIs will get a set budget and be evaluated against outcome based measures that will encourage each contractor to be innovative.

- Dividing responsibilities this way allows CMS to move toward performance based contracting and makes both contractors accountable for achieving specific, desired outcomes.

- Finally, in developing this strategy, we gave careful consideration to two specific program integrity related functions: the role of the Contractor Medical Director (CMD) and cost report audit.

- The CMD activities will remain with the Medicare Carriers and FIs. The education and policy roles of the CMDs are critical to Medicare operations and most essential to reducing payment error.

- While both the Medicare Integrity Program law and our PSC Statement of Work allow for the PSCs to perform cost report audits, we have purposely not included cost report audit in this strategy at this time. This decision is due to limited experience with audit task orders and upcoming changes in audit activities resulting from the transition to prospective payment system methodologies. However, to provide for maximum flexibility, cost report audit is included in each task order should CMS decide to transition this work to the PSCs in the future.

How will this be implemented?

- In developing our Implementation Strategy, we assessed the risks and opportunities associated with a number of transition options.

- After completing this analysis, we decided to adopt a phased approach to PSC implementation and will begin by first competing the fraud and abuse detection and prevention workload <u>in the current jurisdictions</u> of the eight Medicare Carriers and FIs (including RHHIs) that are associated with the PSCs.

- Blue Cross Blue Shield of Alabama
- Empire Blue Cross Blue Shield
- First Coast
- Mutual of Omaha
- Palmetto GBA

- Trailblazers
- National Heritage Insurance Company (NHIC)
- United Government Services (UGS)
- After competing these workloads, we plan to expand our current PSC task orders as appropriate by adding additional States or complimentary A or B workloads, compete the workloads of the remaining Medicare Carriers and FIs, and then make decisions about implementing PSCs at the Durable Medical Equipment Regional Carriers.

PSC Implementation Strategy Schedule:

Phase 1 Contractors: NHIC, UGS, and Trailblazers

Contractor	**Current Workload Jurisdictions**
NHIC	Carrier: California only for this procurement
UGS	FI: California, Hawaii, Michigan, Nevada, Virginia, West Virginia, Wisconsin Regional Home Health Intermediary (RHHI): Washington, Oregon, California, Nevada, Idaho, Arizona, Hawaii, Guam, Puerto Rico, Virgin Islands, New Jersey, New York, Wisconsin, Michigan, Minnesota
Trailblazers	FI: Texas, New Mexico, Colorado Carrier: Texas, Maryland, Delaware, D.C., Virginia

Phase 1 Procurement Schedule:

Release RFPs:	February 25, 2002
Contract Award:	April 30, 2002
Transition:	May 1, 2002 – September 30, 2002
Fully Operational:	October 1, 2002

Phase 2 Contractors: First Coast, Mutual of Omaha, Alabama

Contractor	Current Workload Jurisdictions
First Coast	FI: Florida Carrier: Florida, Connecticut
Mutual of Omaha	FI: Nearly all States
Alabama	FI: Alabama, Iowa, South Dakota RHHI: Montana, Wyoming, Utah, Colorado, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Pennsylvania, Maryland, West Virginia, Virginia, Delaware Carrier: Georgia, Alabama, Mississippi

Phase 2 Procurement Schedule:

Release RFPs:	June 1, 2002
Contract Award:	August 30, 2002
Transition:	August 30, 2002 – December 31, 2002
Fully Operational:	January 1, 2003

Phase 3: Empire BCBS
Palmetto GBA

Procurement Schedule To Be Determined (TBD)

Phase 4: Expand current replacement PSCs as appropriate: Western Integrity Center, Benefit Integrity Support Center, North Carolina PSC, Ohio/West Virginia PSC, and the eight PSC contracts listed above.

Begin January 1, 2003

Phase 5: Compete workloads of remaining Medicare Carrier and FIs (including RHHIs)

Begin January 1, 2003

Phase 6: Compete the DMERC workloads

Procurement Schedule TBD

PSC Implementation Strategy: Questions and Answers

Question 1: Doesn't this strategy really just remove the benefit integrity work from the Carriers and FIs?

Answer 1: This strategy follows an outcomes based approach that makes the PSCs responsible for detecting and preventing fraud and abuse. So, yes, the PSCs will be responsible for performing the traditional benefit integrity activities, like fraud case development and law enforcement support. But the PSCs will also need to perform sophisticated data analysis, as well as some claims review, as part of their overall fraud and abuse detection and prevention strategy.

Question 2: What level of coordination do you expect between the PSCs and the Carriers and FIs?

Answer 2: Any time work is divided between two entities, there needs to be active cooperation and coordination. We will require the PSCs to develop and maintain, along with the Medicare Carriers and FIs, a Joint Operating Agreement that will clearly define the daily operating procedures and coordination points for both contractors. Additionally, we believe that dividing program safeguard work according to these two goals (reducing fraud and abuse and reducing the fee-for-service claims payment error rate) reduces the amount of coordination by making each contractor responsible for performing all activities necessary to achieve their goal.

Question 3: What is the role of the Medicare Fraud Information Specialist (MFIS) under this strategy?

Answer 3: Coordination is essential to this new strategy. Accordingly, we see a continuing role for the MFIS to ensure coordination between CMS, the PSCs, the ACs, law enforcement and others.

Question 4: How does cost report audit fit into this strategy?

Answer 4: While both the Medicare Integrity Program law and our PSC Statement of Work allow for the PSCs to perform cost report audits, we have purposely not included cost report audit in this strategy at this time. This decision is due to limited experience with audit task orders and upcoming changes in audit activities resulting from the transition to prospective payment system methodologies. However, to provide for maximum flexibility, cost report audit is included in each task order should CMS decide to transition this work to the PSCs in the future.

Question 5: When will you re-compete the PSC umbrella contracts and add more contractors to the PSC list?

Answer 5: CMS will re-compete the list of 12 PSCs after our PSC Implementation Strategy is implemented. CMS sponsored a full and open competition for the PSC work in 1998 and, as a result,

awarded contracts to 12 PSCs. Since that time, CMS has publicly committed to moving Medicare Carrier and FI work to the PSCs and has been incrementally implementing PSCs across the country.

Re-competing the PSC schedule at this time would disadvantage the PSCs that have been in the program since the beginning and unfairly open the competition to contractors who now have specific knowledge about our transition plans.

Question 6: Is this strategy designed to move work from the Medicare Carriers and FIs currently performing this work under one contract to the same entity's PSC contract?

Answer 6: All of these procurements will be awarded on a competitive basis, therefore we are not assuming that a PSC will automatically win the work of its affiliate.

It is however, one of our primary goals to transition certain program safeguard activities to the PSCs. Having these contracts will give us flexibility to add or subtract work as necessary, make the PSCs more accountable for their work, and allow CMS to offer incentives and reward good work.

Question 7: Won't this strategy unfairly advantage the PSCs that are affiliated with the Carriers and FIs?

Answer 7: All of these procurements will be competitively awarded. All PSCs have inherent, unique strengths that may give them an advantage as they develop their proposals regardless of their association with any particular Carrier or FI.

Question 8: Why didn't you just give the PSCs the work of their affiliated Medicare Carriers and FIs?

Answer 8: The Medicare Integrity Program law, Section 1893 (a)(2)(B), requires that as we move work away from Medicare Carriers and FIs, we do so on a competitive basis. We sponsored a full and open competition in 1998 to establish the twelve PSC contracts, and now, as we award PSC task orders under these Indefinite Delivery, Indefinite Quantity contracts, the Federal Acquisition Regulation requires that each organization be given a "fair opportunity for consideration." Additionally, from a programmatic perspective, we believe that competition will yield additional positive results.

Question 9: How will CMS address any actual and/or perceived Conflict of Interest issues associated with this strategy?

Answer 9: One of the reasons the Medicare Integrity Program was enacted was to reduce potential conflict of interest issues associated with a company performing program safeguard activities on the claims they process or on a provider that may be affiliated with their private lines of business. All of our PSCs are required to adhere to the conflict of interest provisions in the draft Medicare Integrity Program regulation and develop mitigation plans for any perceived or actual conflict. CMS will not award work to a PSC that has an unmitigated conflict associated with that line of work.

Question 10: When will you announce the sequence and timeline for competing the workload of the remaining Medicare Carriers and FIs?

Answer 10: We expect to announce a more definitive schedule for the remaining Medicare Carriers and FIs early next year.

Question 11: Why aren't you creating more geographically based PSCs?

Answer 11: In order to create geographically based PSCs, the PSCs would have to work with multiple Medicare Carriers and FIs, data centers, and standard systems operating in a given geographical area. Maintaining a 1 to 1, PSC to Medicare Carrier and/or FI, relationship mitigates the potential risks associated with transitioning work from multiple entities at once and coordinating daily operations with multiple entities.

However, it is important to note that, although we are competing the fraud and abuse detection and prevention workloads of the Medicare Carriers and FIs under their current contractor jurisdictions, we may in the future re-align PSC work based on contracting reform decisions or to create more geographically based PSCs.

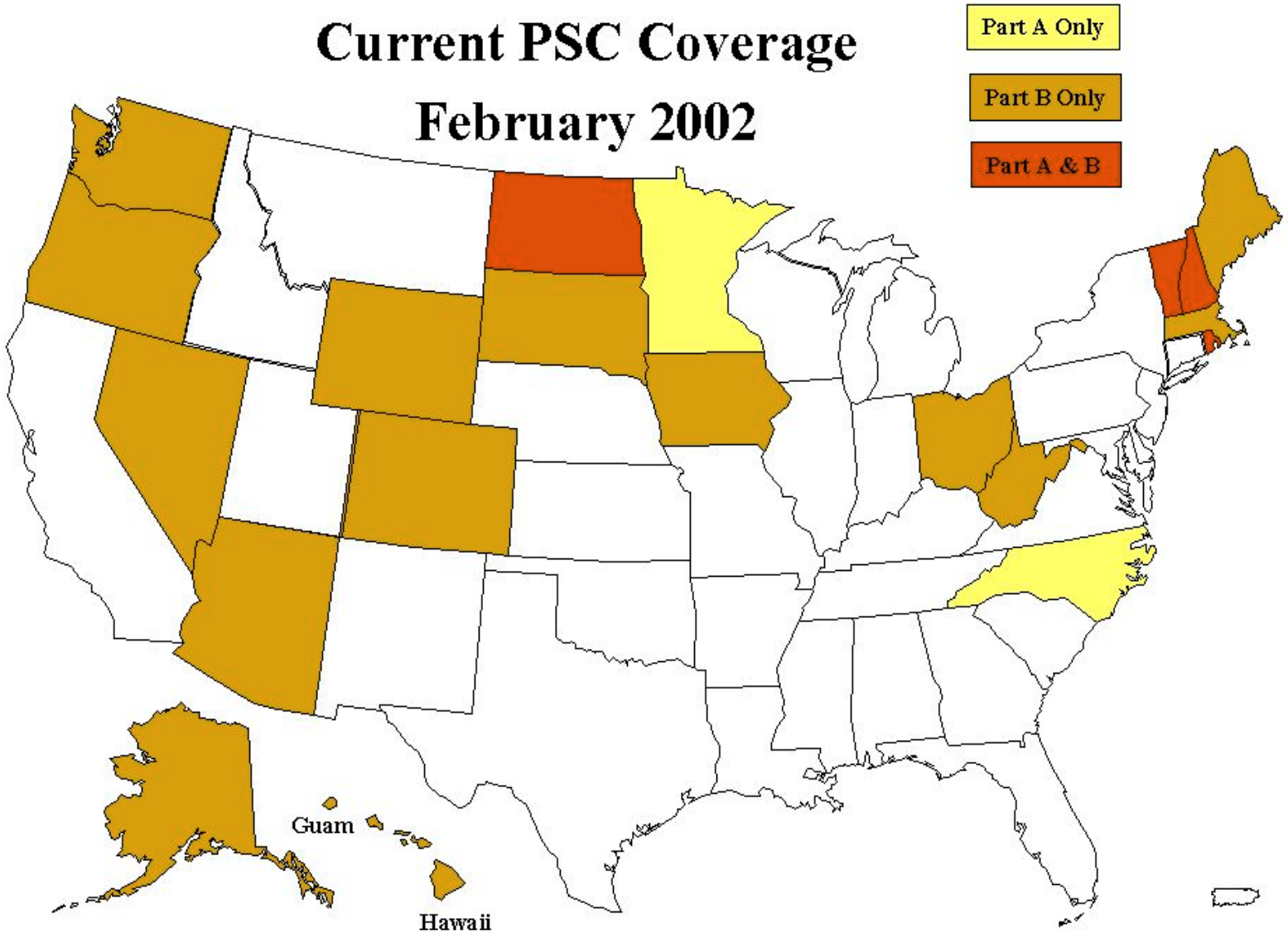
Question 12: What will happen to the current PSC operations like the Western Integrity Center and the North Carolina PSC?

Answer 12: Currently, there are five PSCs operating under slightly different configurations, including the post-payment Western Integrity Center and the North Carolina PSC. We plan to make decisions about potentially re-configuring or expanding these PSC operations after we have competed, awarded and transitioned the PSC workloads of the eight Medicare Carriers and FIs that are affiliated with the PSCs.

Question 13: How does your strategy apply to the Durable Medical Equipment Regional Carriers (DMERCs)?

Answer 13: The primary goal of this strategy is to transition the fraud and abuse detection and prevention activities of the Medicare Carriers and FIs (including Regional Home Health Intermediaries) to the PSCs. Because the DMERCs are a very specific, consolidated specialty contractor operation, we are not planning to transition any additional DMERC work to the PSCs at this time. Further, since the PSC DMERC for Region A has only been fully operational for just over three months, we want to evaluate that operation more thoroughly before moving forward.

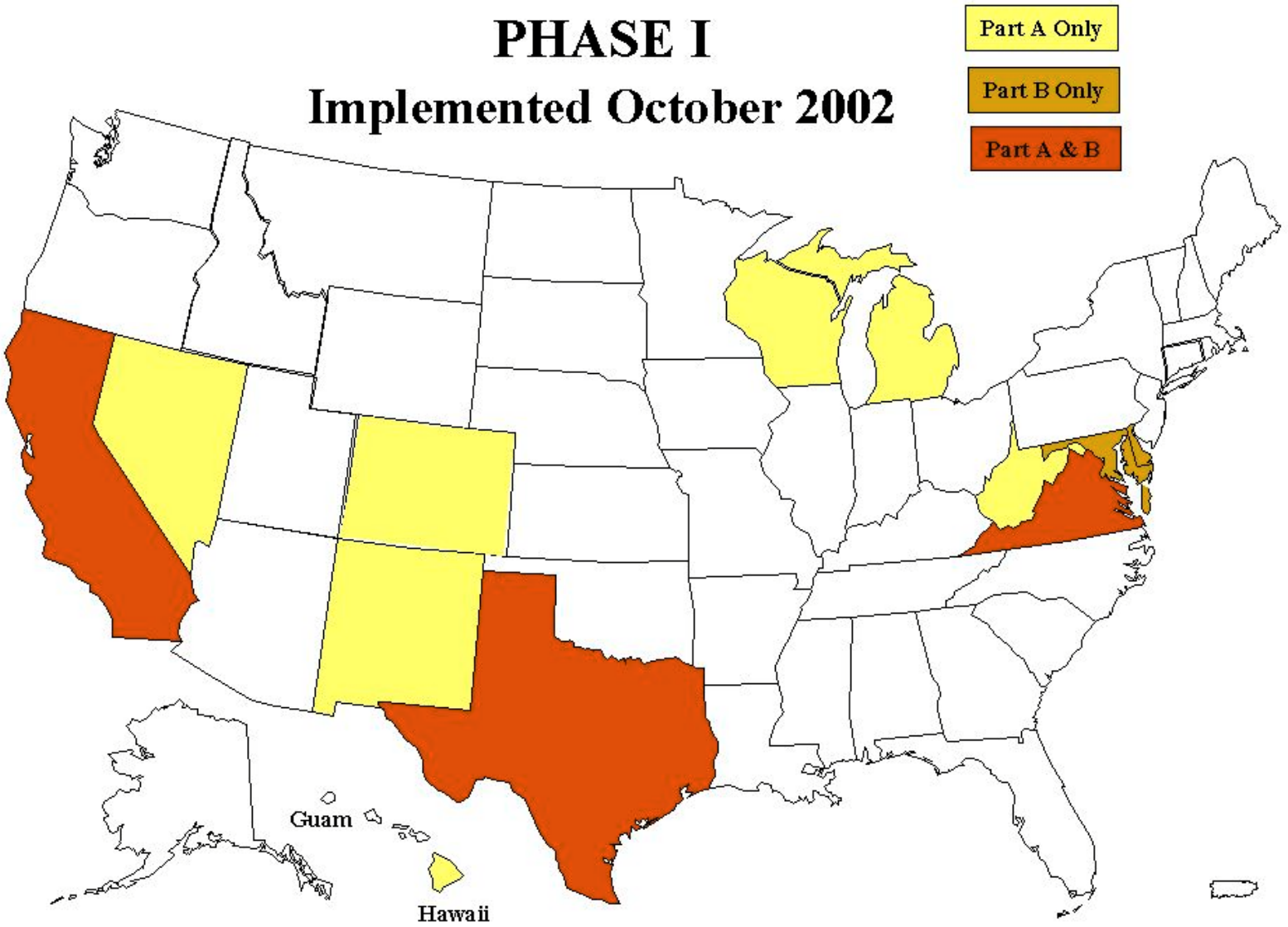
Current PSC Coverage
February 2002



This map depicts the jurisdictions of the Benefit Integrity Support Center, the North Carolina PSC, the Ohio and West Virginia PSC, and the Western Integrity Center.

PHASE I

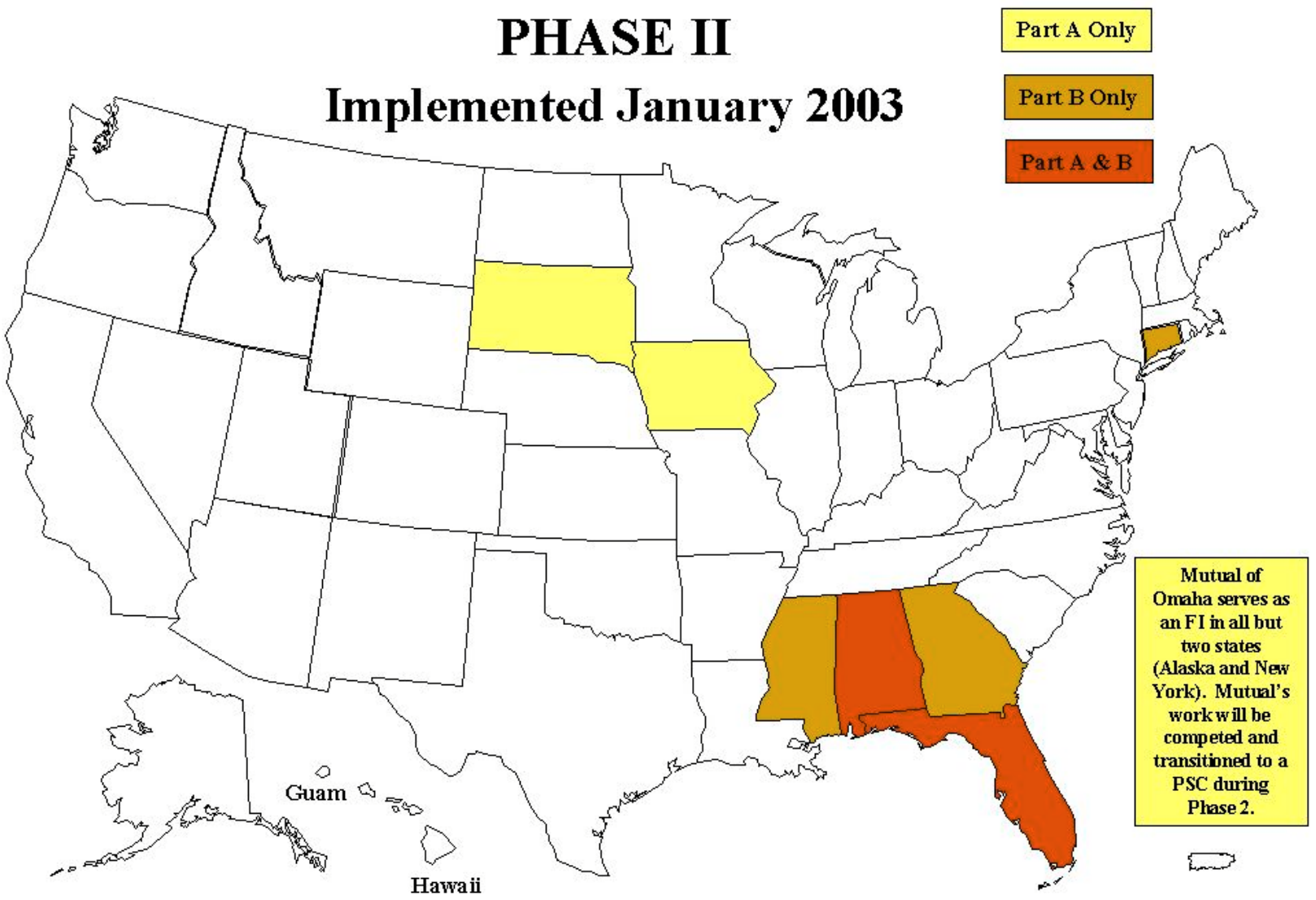
Implemented October 2002



This slide depicts the Phase I implementation of Carrier and FI workloads for NHIC (California Only), UGS, and Trailblazers. UGS's RHHI workload is not shown, but will be competed and transitioned to a PSC in Phase I.

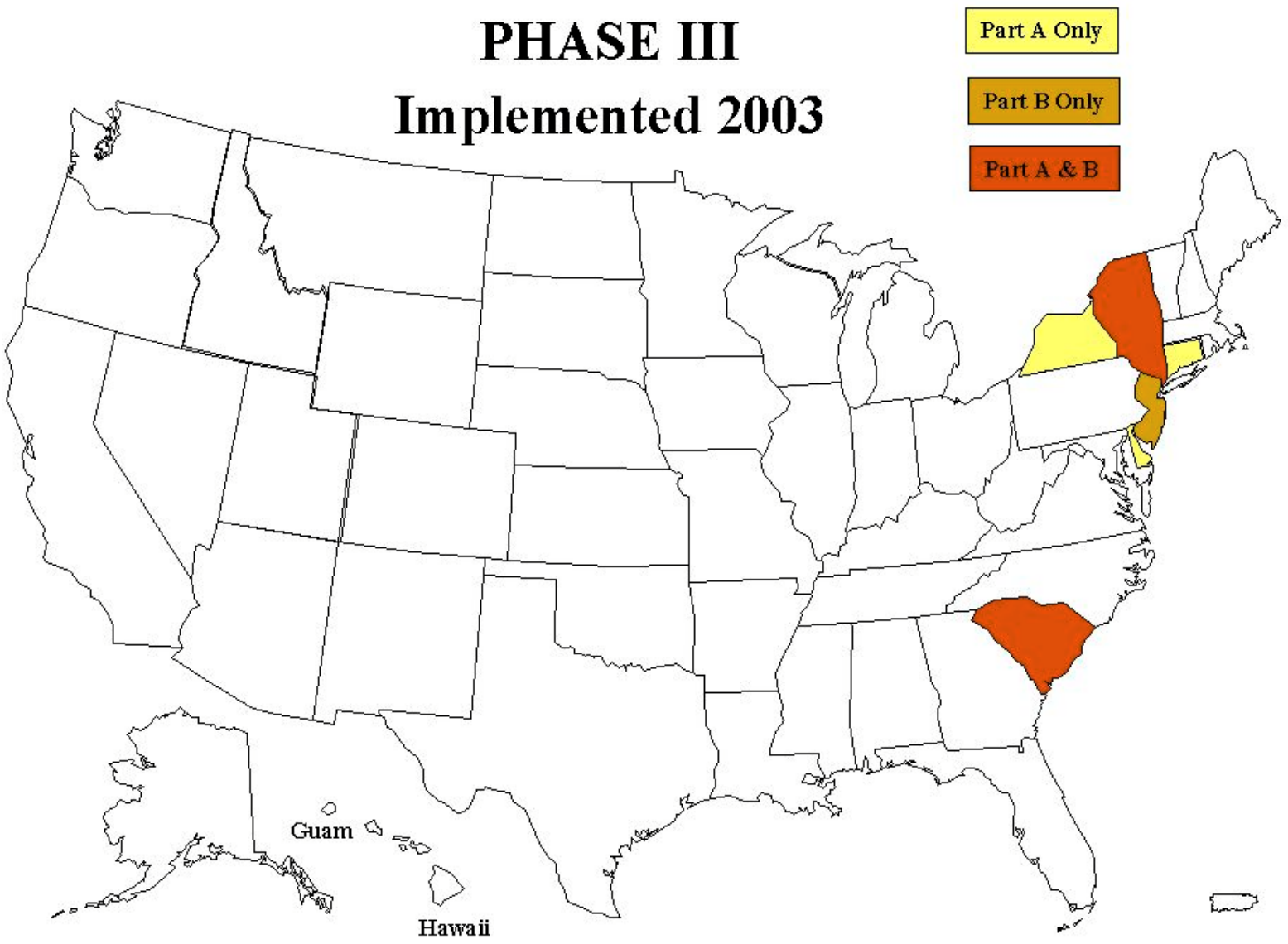
PHASE II

Implemented January 2003



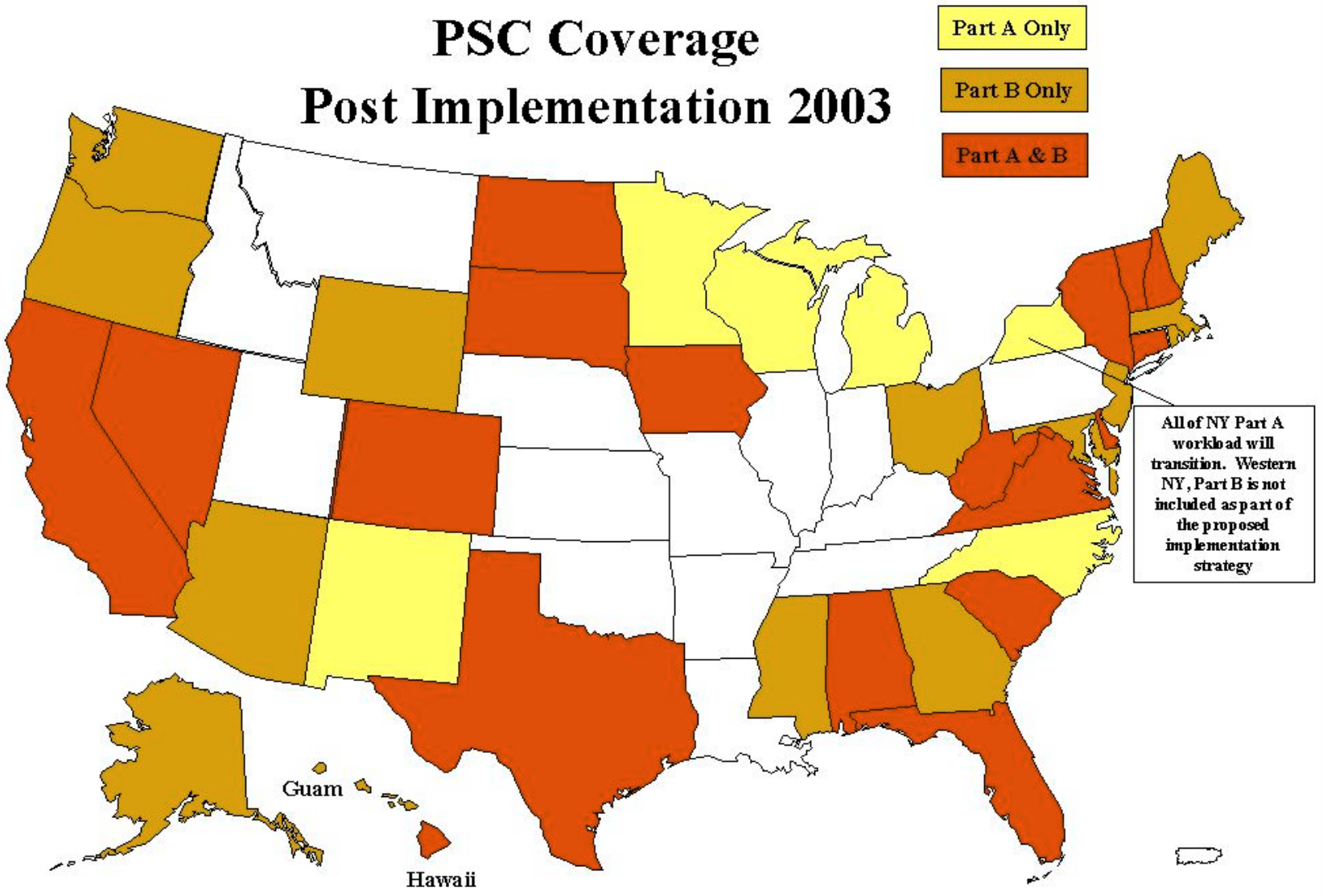
This slide depicts Phase II implementation of Carrier and FI workloads for First Coast, Cahaba, and Mutual of Omaha. Cahaba's RHHI workload is not shown, but it will be competed and transitioned to a PSC during Phase II.

PHASE III
Implemented 2003



This slide depicts Phase III implementation of Carrier and FI workloads for Palmetto GBA and Empire BCBS.
Palmetto's RHHI workload is not shown, but will be competed and transitioned to a PSC during Phase III.

PSC Coverage
Post Implementation 2003



Mutual of Omaha's FI work and the RHHI work of UGS, Cahaba, and Palmetto are not shown, but they will be covered by a PSC.

NOTE: In the red colored states, more than one PSC may be operating- one for Part A and one for Part B.

Intermediary-Carrier Directory
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

- Section I: Part A Intermediaries and Part B Carriers by State
- Section II: Part A Intermediaries and Part B Carriers
- Section III: Commercial and Independents - Parts A & B
- Section IV: Regional Home Health Intermediaries, Durable Medical Equipment Regional Carriers, Common Working File Host Contractors, Rural Health Clinics

Communicating with Intermediaries and Carriers
Medicare contracts cover the rights and obligations of Intermediaries, Carriers, and the Secretary of Health and Human Services. Requests for action or information not specifically authorized by such contracts should not be made. Any questions in this regard should be addressed to the Office of Internal Customer Support, Acquisition and Grants Group, Division of Medicare Contractors.

Abbreviations
RHC - Rural Health Clinics
CHC - Community Health Centers
CSC - Christian Science Centers
HHA - Home Health Agencies
HL - Histocompatibility Labs (Independent)
OPA - Organ Procurement Agencies (Independent)
PE - Parenteral/Enteral
DME - Durable Medical Equipment
LPIC - Limited Purpose Insurance Company
RRB - SC.

Effective Date: February 2002

http://www.hcfa.gov/medicare/incardir.htm

SECTION I

PART A INTERMEDIARIES AND PART B CARRIERS BY STATE

Alabama(Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of Alabama; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Alabama
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

Alaska (Regional Office: Seattle)
Part A - Premera Blue Cross; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

American Samoa
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Arizona (Regional Office: San Francisco)
Part A - Blue Cross and Blue Shield of Arizona; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Arkansas (Regional Office: Dallas)
Part A - Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company; Mutual of Omaha Insurance Company
Part B - Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company

RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

California (Regional Office: San Francisco)
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - National Heritage Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Colorado (Regional Office: Denver)
Part A - TrailBlazer Health Enterprises, LLC; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Blue Cross and Blue Shield of South Carolina

Connecticut (Regional Office: Boston)
Part A - Empire HealthChoice, Inc.; Mutual of Omaha Insurance Company
Part B -Blue Cross and Blue Shield of Florida, Inc. (First Coast Service Options)
RHHI - Associated Hospital Service of Maine
DMERC - HealthNow New York, Inc.

Delaware (Regional Office: Philadelphia)
Part A - Empire HealthChoice, Inc.; Mutual of Omaha Insurance Company
Part B - TrailBlazer Health Enterprises, LLC
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - HealthNow New York, Inc.

District of Columbia (Regional Office: Philadelphia)
Part A - CareFirst of Maryland, Inc.; Mutual of Omaha Insurance Company
Part B - TrailBlazer Health Enterprises, LLC
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - AdminaStar Federal, Inc.

Florida (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of Florida, Inc. (First Coast Service Options); Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Florida, Inc. (First Coast Service Options)
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

Georgia (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of Georgia, Inc.; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Alabama
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

Guam (Regional Office: San Francisco)
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI -
DMERC - Connecticut General Life Insurance Company

Hawaii (Regional Office: San Francisco)
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Idaho (Regional Office: Seattle)
Part A - Regence BlueCross BlueShield of Oregon; Mutual of Omaha Insurance Company
Part B - Connecticut General Life Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Illinois (Regional Office: Chicago)
Part A - Anthem Insurance Companies, Inc.; Mutual of Omaha Insurance Company
Part B - Wisconsin Physicians Service
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - AdminaStar Federal Inc.

Indiana (Regional Office: Chicago)
Part A - Anthem Insurance Companies, Inc.; Mutual of Omaha Insurance Company
Part B - AdminaStar Federal, Inc.
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - AdminaStar Federal Inc.

Iowa (Regional Office: Kansas City)
Part A - Blue Cross and Blue Shield of Alabama; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Kansas (Regional Office: Kansas City)
Part A - Blue Cross and Blue Shield of Kansas, Inc.; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Kansas, Inc.
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Kentucky (Regional Office: Atlanta)
Part A - Anthem Insurance Companies, Inc.; Mutual of Omaha Insurance Company
Part B - AdminaStar Federal, Inc.
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

Louisiana (Regional Office: Dallas)
Part A - Blue Cross and Blue Shield of Mississippi; Mutual of Omaha Insurance Company
Part B - Arkansas Blue Cross and Blue Shield
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - Blue Cross and Blue Shield of South Carolina

Maine (Regional Office: Boston)
Part A - Anthem Health Plans of Maine, Inc.; Mutual of Omaha Insurance Company
Part B - National Heritage Insurance Company
RHHI - Anthem Health Plans of Maine, Inc.
DMERC - HealthNow New York, Inc.

Maryland (Regional Office: Philadelphia)
Part A - CareFirst of Maryland, Inc.; Mutual of Omaha Insurance Company
Part B - TrailBlazer Health Enterprises, LLC
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - AdminaStar Federal Inc.

Massachusetts (Regional Office: Boston)
Part A - Anthem Health Plans of Maine, Inc.; Mutual of Omaha Insurance Company
Part B - National Heritage Insurance Company
RHHI - Anthem Health Plans of Maine, Inc.
DMERC- HealthNow New York, Inc.

Michigan (Regional Office: Chicago)
Part A - Blue Cross Blue Shield United of Wisconsin; United Health Care Insurance Company; Mutual of Omaha Insurance Company
Part B - Wisconsin Physicians Service
RHHI - Blue Cross and Blue Shield of South Carolina
DMERC - AdminaStar Federal Inc.

Minnesota (Regional Office: Chicago)
Part A - Noridian Mutual Insurance Company; Mutual of Omaha Insurance Company
Part B - Wisconsin Physicians Service
RHHI - Blue Cross and Blue Shield United of Wisconsin
DMERC - AdminaStar Federal Inc.

Mississippi (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of Mississippi; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Alabama
RHHI - Blue Cross Blue Shield South Carolina
DMERC - Blue Cross Blue Shield South Carolina

Missouri (Regional Office: Kansas City)
Part A - Blue Cross and Blue Shield of Mississippi; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Kansas, Inc. (Western Missouri); Arkansas Blue Cross Blue Shield (Eastern Missouri)
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Montana (Regional Office: Denver)
Part A - Blue Cross and Blue Shield of Montana, Inc.; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Montana, Inc.
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Nebraska (Regional Office: Kansas City)
Part A - Blue Cross and Blue Shield of Nebraska; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Kansas, Inc.
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Nevada (Regional Office: San Francisco)
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

New Hampshire (Regional Office: Boston/San Francisco)
Part A - Anthem Health Plans of New Hampshire, Inc.; Mutual of Omaha Insurance Company
Part B - National Heritage Insurance Company
RHHI - Anthem Health Plans of New Hampshire Inc.
DMERC - HealthNow New York, Inc.

New Jersey (Regional Office: New York)
Part A - Blue Cross Blue Shield of Tennessee; Mutual of Omaha Insurance Company
Part B - Empire HealthChoice, Inc.
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC- HealthNow New York, Inc.

New Mexico (Regional Office: Dallas)
Part A - Trailblazer Health Enterprises, LLC; Mutual of Omaha Insurance Company
Part B - Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company
RHHI - Blue Cross Blue Shield South Carolina
DMERC - Blue Cross Blue Shield South Carolina

New York (Regional Office: New York)
Part A - Empire HealthChoice, Inc.; Mutual of Omaha Insurance Company
Part B - HealthNow New York Inc.; Empire HealthChoice, Inc.; Group Health Incorporated
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - HealthNow New York, Inc.

North Carolina (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of South Carolina; Mutual of Omaha Insurance Company
Part B - Connecticut General Life Insurance Company
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - Blue Cross Blue Shield of South Carolina

North Dakota (Regional Office: Denver)
Part A - Noridian Mutual Insurance Company; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Northern Marianna Islands (Regional Office: San Francisco)
Part A - Blue Cross Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC- Connecticut General Life Insurance Company

Ohio (Regional Office: Chicago)
Part A - Anthem Insurance Companies, Inc.; Mutual of Omaha Insurance Company
Part B - Nationwide Mutual Insurance Company
RHHI - Blue Cross Blue Shield of South Carolina
DMERC- AdminaStar Federal Inc.

Oklahoma (Regional Office: Dallas)
Part A - Group Health Service of Oklahoma, Inc.; Mutual of Omaha Insurance Company
Part B - Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - Blue Cross Blue Shield of South Carolina

Oregon (Regional Office: Seattle)
Part A - Regence BlueCross BlueShield of Oregon; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

Pennsylvania (Regional Office: Philadelphia)
Part A - Highmark, Inc.; Mutual of Omaha Insurance Company
Part B - Highmark, Inc.
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - HealthNow New York, Inc.

Puerto Rico (Regional Office: New York)
Part A - Cooperative de Seguros de Vida de Puerto Rico; Mutual of Omaha Insurance Company
Part B - Triple-S, Inc,
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Blue Cross Blue Shield of South Carolina

Rhode Island (Regional Office: Boston)
Part A - Blue Cross and Blue Shield of Rhode Island; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Rhode Island
RHHI - Associated Hospital Service of Maine
DMERC - HealthNow New York, Inc.

South Carolina (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of South Carolina; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of South Carolina
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - Blue Cross Blue Shield of South Carolina

South Dakota (Regional Office: Denver)
Part A - Blue Cross and Blue Shield of Alabama; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Tennessee (Regional Office: Atlanta)
Part A - Blue Cross and Blue Shield of Tennessee; Mutual of Omaha Insurance Company
Part B - Connecticut General Life Insurance Company
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - Blue Cross Blue Shield of South Carolina

Texas (Regional Office: Dallas)
Part A - TrailBlazer Health Enterprises, LLC; Mutual of Omaha Insurance Company
Part B - TrailBlazer Health Enterprises, LLC
RHHI - Blue Cross Blue Shield of South Carolina
DMERC - Blue Cross Blue Shield of South Carolina

U.S. Virgin Islands (Regional Office: New York)
Part A - Cooperative de Seguros de Vida de Puerto Rico; Mutual of Omaha Insurance Company
Part B - Triple-S, Inc.
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Blue Cross Blue Shield of South Carolina

Utah (Regional Office: Denver)
Part A - Regence BlueCross BlueShield of Oregon; Mutual of Omaha Insurance Company
Part B - Blue Cross and Blue Shield of Utah
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

Vermont (Regional Office: Boston/San Francisco)
Part A - Anthem Health Plans of New Hampshire, Inc.; Mutual of Omaha Insurance Company
Part B - National Heritage Insurance Company
RHHI - Anthem Health Plans of Maine, Inc.
DMERC - HealthNow New York, Inc.

Virginia (Regional Office: Philadelphia)
Part A - Blue Cross Blue Shield United of Wisconsin ; Mutual of Omaha Insurance Company
Part B - TrailBlazer Health Enterprises, LLC
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - AdminaStar Federal Inc.

Washington (Regional Office: Seattle)
Part A - Premera Blue Cross Blue Shield; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross Blue Shield United of Wisconsin
DMERC - Connecticut General Life Insurance Company

West Virginia (Regional Office: Philadelphia)
Part A - Blue Cross Blue Shield United of Wisconsin ; Mutual of Omaha Insurance Company
Part B - Nationwide Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - AdminaStar Federal Inc.

Wisconsin (Regional Office: Chicago)
Part A - Blue Cross and Blue Shield United of Wisconsin; Mutual of Omaha Insurance Company
Part B - Wisconsin Physicians Service Insurance Corporation
RHHI - Blue Cross and Blue Shield United of Wisconsin
DMERC - AdminaStar Federal Inc.

Wyoming (Regional Office: Denver)
Part A - Blue Cross and Blue Shield of Wyoming; Mutual of Omaha Insurance Company
Part B - Noridian Mutual Insurance Company
RHHI - Blue Cross and Blue Shield of Alabama
DMERC - Connecticut General Life Insurance Company

SECTION II

PART A INTERMEDIARIES AND PART B CARRIERS

BLUE CROSS AND BLUE SHIELD ASSOCIATION
225 North Michigan Avenue
Chicago, Illinois 60601-7680
PHONE: 312-297-6000
FAX: 312-297-6609

PART A - AGREEMENT NO. HCFA 87-001-1

Scott P. Serota
Acting President & Chief
Executive Officer
PHONE:312-297-6010 Harvey W. Friedman
Contracting Officer
Medicare Administration
PHONE:312-297-6245

ALABAMA PART A PROVIDER SERVICE AREA: States of Alabama, Iowa and South Dakota Special Claims: Home Health
PART B JURISDICTION: States of Alabama, Georgia, Mississippi

PART A - AGREEMENT NO. HCFA 87-001-1.1
PART B - CONTRACT NO. HCFA 87-003-2

Charles R. Hartsell
President & CEO
Cahaba Government
Benefit Administrators
PHONE: 205-220-4835 Lynda Northcutt
Vice President
Medicare Administration
Cahaba Government Benefit Administrators
P.O. Box 830139
Birmingham, AL 35283-0139
PHONE: 205-220-4835
FAX: 205-220-4841

Corporate Office
Cahaba Government Benefit Administrators
A Division of BLUE CROSS AND BLUE SHIELD OF ALABAMA
P.O. Box 830139
Birmingham, Alabama 35283-0139

Corporate Office - Overnight Packages Only
Cahaba Government Benefit Administrators
A Division of Blue Cross and Blue Shield of Alabama
Medicare Claims Administration
MSID-F00005
450 Riverchase Parkway East
Birmingham, AL 35244
PHONE: 205-220-2100
FAX: 205-220-4841
Web Site: www.cahabagba.com

ALABAMA OFFICE – Medicare Intermediary & Carrier

Beneficiary Customer Service – 1-800-292-8855
Provider Line - 1-866-539-5598
INTERNET: almedicare@bcbsal.org
Web Site: www.cahabagba.com

Robert Orr
Executive Director
Alabama Medicare Operations
P.O. Box 830139
Birmingham, Alabama 35283-0139

OVERNIGHT PACKAGES ONLY
Cahaba Government Benefit Administrators
Alabama Medicare Claims Administration
MSID-F00005
450 Riverchase Parkway East
Birmingham, AL 35244

PHONE: 205-220-4842
FAX: 205-220-4841

GEORGIA OFFICE – Medicare Carrier

Beneficiary Customer Service – 1-800-727-0827
Provider Line – 912-927-0934 – Toll Free – 1-877-567-7271

Leigh Forman
Executive Director
Georgia Medicare Operations
12052 Middleground Rd., Suite A
Savannah, GA 31419-1699
PHONE: 912-921-3087
FAX: 912-921-4635
INTERNET: gamedicare@bcbsal.org
Web Site: www.cahabagba.com

IOWA OFFICE - Medicare Intermediary, Regional Home Health Intermediary for Colorado, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, Washington DC, West Virginia, and Wyoming

Beneficiary line - 1-877-910-8139
Provider Line -

Home Health - 877-299-4500
Hospice - 866-539-5592
Other providers - 877-567-3092
MSP (attorneys and insurers) - 515-471-7400

Susan Pretnar
Executive Director
Midwest Medicare Operations
400 E. Court Avenue, Station 158
Des Moines, IA 50309-2017

PHONE: 515-471-7302
FAX: 515-471-7222
INTERNET: iamedicare@cahabagba.com
Web Site: www.cahabagba.com

MISSISSIPPI OFFICE - Medicare Carrier

Beneficiary Customer Service - 1-800-682-5417
Provider Line - 1-866-419-9454

John Cook
Executive Director
Mississippi Medicare Operations
P.O. Box 22545
Jackson, MS 39225-2545

OVERNIGHT PACKAGES ONLY
775 Woodlands Parkway
Ridgeland, MS 39157-5212

PHONE: 601-977-5850
FAX: 601-956-2738
INTERNET: msmedicare@cahabagba.com
Web Site: www.cahabagba.com

ALASKA PART A PROVIDER SERVICE AREA - See Premera Blue Cross (Blue Cross of Washington and Alaska)
PART B JURISDICTION - See Blue Cross Blue Shield of North Dakota

ARIZONA PART A PROVIDER SERVICE AREA : State of Arizona
PART B JURISDICTION - See Blue Cross Blue Shield of North Dakota

BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.
P.O. Box 37700
Phoenix, Arizona 85069
STREET ADDRESS:
2444 West Palmaritas Drive
Phoenix, Arizona 85021
PHONE: 602-864-4400
FAX: 602-864-4041
INTERNET:crich@phx1.bcbsaz.com

PART A- AGREEMENT NO. HCFA 87-001-1.2

Robert B. Bulla
President and Chief
Executive Officer
PHONE: 602-864-4444

Susie Nash
Vice President of Federal Programs
PHONE: 602-864-4423

Jody Chandler
Senior Vice President
Claims and Federal Programs
PHONE: 602-864-4445

Karen Abraham
Vice President and Controller of Finance
PHONE: 602-864-5700

ARKANSAS PART A PROVIDER SERVICE AREA: State of Arkansas
PART B JURISDICTION: States of Arkansas , Louisiana, Oklahoma, New Mexico, Eastern Missouri

ARKANSAS BLUE CROSS AND BLUE SHIELD
A MUTUAL INSURANCE COMPANY
STREET ADDRESS:
601 Gaines Street
Little Rock, Arkansas 72201
PHONE: 501-378-2000
FAX: 501-378-2804
INTERNET:tlwhite@arkbluecross.com

PART A - AGREEMENT NO. HCFA 87-001-1.3
PART B - CONTRACT NO . HCFA-87-004-2

Robert L. Shoptaw
President & CEO
PHONE: 501-378-2242

Sharon K. Allen
Executive Vice President
PHONE: 501-378-2145

Charles Clem
Vice President
Public Programs
PHONE: 501-378-2476

Theresa Milligan
Director, Medicare Adm Support
Phone: 501-378-2078

Amanda Crosby
Manager, Provider Audit and
Reimbursement
PHONE: 501-918-7469

Arkansas Part A
Provider: 1-866-548-0527
Beneficiary: 1-877-356-2368

Arkansas Part B
Provider: 1-877-908-8434
Beneficiary: 1-800-482-5525

Louisiana Part B Operations
P.O. Box 98501
Baton Rouge, LA 70884
Bobbye Garner
Director Louisiana Part B Operations
Phone: 501-378-2250
Provider: 1-877-567-7204
Beneficiary: 1-800-392-3070

Oklahoma/New Mexico Part B Operations
1701 NW 63rd
Oklahoma City, OK 73116
Lanny Day
Director Oklahoma/New Mexico Operations
Phone:405-848-6257
Provider OK/NM: 1-877-567-9230
Beneficiary OK: 1-800-522-9079
Beneficiary NM: 1-800-423-2925

Eastern Missouri
12755 Olive Street
St Louis, Missouri 63141
Carl Messina
Director of Missouri Medicare Operations
PHONE: 314-212-1705
Provider: 1-866-539-5599
Beneficiary: 1-800-392-3070

CALIFORNIA PART A PROVIDER SERVICE AREA: Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION: See National Heritage Insurance Company

COLORADO PART A PROVIDER SERVICE AREA - See TrailBlazer Health Enterprises, LLC and Blue Cross and Blue Shield of South Carolina (HHA only).
PART B JURISDICTION - See Noridian Mutual Insurance Co. (North Dakota)

CONNECTICUT See Empire HealthChoice, Inc.
PART B JURISDICTION - See Blue Cross and Blue Shield of Florida, Inc. (First Coast Service Options)

DELAWARE PART A PROVIDER SERVICE AREA: See Empire HealthChoice, Inc.
PART B JURISDICTION - See (Texas) Trailblazer Health Enterprises, LLC

DISTRICT OF COLUMBIA PART A PROVIDER SERVICE AREA - See Care First of Maryland
PART B JURISDICTION - See (Texas) Trailblazer Health Enterprises, LLC

FLORIDA PART A PROVIDER SERVICE AREA: State of Florida
PART B JURISDICTION: State of Florida, Connecticut

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

PART A - AGREEMENT NO. HCFA 87-001-1.10
PART B - CONTRACT NO. HCFA-87-009-2

FIRST COAST SERVICE OPTIONS, INC. (FLORIDA)
MEDICARE
532 Riverside Avenue
Jacksonville, Florida 32202

MEDICARE A & B BENEFICIARY-TOLL-FREE: 1-800-333-7586
MEDICARE B PROVIDER-TOLL-FREE: 1-877-847-4992
MEDICARE B PROVIDER - CSR CALLS - 1-866-454-9007
MEDICARE A PROVIDER ONLY - 1-877-602-8816

PART A Mailing Address (Claims and Correspondence)
P.O. Box 2711
Jacksonville, FL 32231-0021

INTERNET: Providers - floridamedicare.com
Beneficiaries - medicarefla.com

P. O. Box 2525
Jacksonville, FL 32231-0048

P.O. Box 2360 (Correspondence)
Jacksonville, FL 32231-0048

First Coast Services Options, Inc.
Curtis Lord
President & CEO
532 Riverside Avenue
Jacksonville, FL 32202
PHONE: 904-791-8090

First Coast Services Options, Inc.
Patricia A. Williams
Sr. Vice President and COO
PHONE: 904-791-8155

Program Management A/B
Lamar James
Vice President
PHONE: 904-791-8358

Government Safeguards A/B
Patricia Ainsley
Vice President
PHONE: 904-791-8136

PART B Mailing Address (Claims)
FIRST COAST SERVICE OPTIONS, INC. (CONNECTICUT - PART B ONLY)
321 Research Parkway
Meriden, CT 06540-7148

BENEFICIARY - TOLL-FREE - 1-800-982-6819
PROVIDER - TOLL FREE - 1-866-419-9455
CUSTOMER SERVICE: 203-639-3000

Mailing Address (Claims and Correspondence)
P. O. Box 9000
Meriden, CT 06540

Program Management B
Lamar James
Vice President
PHONE: 904-791-8358 Program Safeguards B
Patricia Ainsley
Vice President
PHONE: 904-791-8136

Shirley Edlin
Director
PHONE: 203-634-5409

GEORGIA PART A PROVIDER SERVICE AREA: State of Georgia
PART B JURISDICTION - See Blue Cross and Blue Shield of Alabama

BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.
3350 Peachtee Road, N.E.
Atlanta, Georgia 30326
PHONE: 706-571-5371(Columbus)
PHONE: 404-842-8000(Atlanta)
FAX: 706-571-5431
INTERNET: www.georgiamedicare.com

PART A - AGREEMENT NO. HCFA 87-001-1.11

Richard D. Shirk
President and Chief Executive Officer
PHONE: 404-842-8410

Neil Vannoy
Executive Vice President
Community Operations
3350 Peachtree Road, NE
P.O. Box 4445
PHONE: 404-842-8420
FAX: 404-842-8451

Wanda M. Logan
Assistant Vice President
Medicare Claims Operations
2357 Warm Springs Rd.
Columbus, GA 31904
P.O. Box 9048
Columbus, GA 31908-9048
PHONE: 706-571-5260

Robert M. Unwin
Assistant Vice President
Provider Audit & Reimbursement
2357 Warm Springs Rd.
Columbus, GA 31904
P.O. Box 9048
Columbus, GA 31908-9048
PHONE: 706-257-1083

HAWAII PART A PROVIDER SERVICE AREA - See Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION - See Noridian Mutual Insurance Co. (North Dakota)

IDAHO PART A PROVIDER SERVICE AREA - See Regence BlueCross BlueShield of Oregon
PART B JURISDICTION - See Connecticut General Life Insurance Company

ILLINOIS PART A PROVIDER SERVICE AREA: See Anthem Insurance Companies, Inc.
PART B JURISDICTION: See Wisconsin Physicians Service and National Heritage Insurance Co.

INDIANA PART A PROVIDER SERVICE AREA: States of Illinois, Indiana, Kentucky, Ohio

ANTHEM INSURANCE COMPANIES, INC.
120 Monument Circle, Suite 200
Indianapolis, Indiana 46204
PHONE: 317-488-6000 (Corporate Office-Anthem)
FAX: 317-841-4691
INTERNET: www.adminastar.com Medicare Operations
AdminaStar Federal, Inc.
8115 Knue Road
Indianapolis, IN 46250
PHONE: 317-841-4400 (Operations Office-Adminastar, Inc.)

PART A -AGREEMENT NO. HCFA 88-001-1.16

Mike McCarron, President
Chief Operating Officer
8115 Knue Road
Indianapolis, Indiana 46204
PHONE: 317-841-4510

William R. Vandervennet, Jr.
Chairman of the Board
AdminaStar Federal, Inc.
120 Monument Circle
Suite 200
Indianapolis, Indiana 46204
PHONE: 317-488-6093

Julie Daniel
Executive Director, Intermediary Program Management
8115 Knue Road
Indianapolis, Indiana 46250
PHONE: 317-297-4799 Tim Masheck
Executive Director, IT Services
PHONE: 317-841-4523

Dennis Brinker
Executive Director, Audit and Reimbursement
PHONE: 317-841-4429 Sharon Weddel
Executive Director, Benefits Integrity
PHONE: 317-841-4644

Chance Bunger
Regional Compliance Officer
PHONE: 317-841-4499

INDIANA PART B JURISDICTION: States of Indiana, Kentucky
DME REGIONAL CARRIER: District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia,West Virginia, Wisconsin (PE)

ADMINASTAR FEDERAL, INC.
8115 Knue Road
Indianapolis, Indiana 46250
PHONE: 317-841-4400 (Operations Office)
FAX: 317-841-4691
INTERNET: www.adminastar.com

PART B - HCFA CONTRACT NO. 88-011-2 DMERC
CONTRACT: 500-93-BPO2

Mike McCarron, President
Chief Operating Officer
8115 Knue Road
Indianapolis, Indiana 46250
PHONE: 317-841-4510

David Marshall
Executive Director, Customer Service
PHONE: 317-841-4448 Sharon Weddel
Executive Director, Benefits Integrity
PHONE: 317-841-4644

William R. Vandervennet, Jr.
Chairman of the Board
AdminaStar Federal, Inc.
120 Monument Circle
Suite 200
Indianapolis, Indiana 46204
PHONE: 317-488-6093

Christine Beard
Executive Director, Carrier & DMERC
Program Management
PHONE: 317-841-4514 Tim Masheck
Executive Director, IT Services
PHONE: 317-841-4523

DURABLE MEDICAL EQUIPMENT
AdminaStar Federal
ATTN: DMERC Operations
8115 Knue Road
Indianapolis, IN 46250
DMERC CONTRACT: 500-93-BPO2
INTERNET: www.adminastar.com

IOWA PART A PROVIDER SERVICE AREA: See Blue Cross and Blue Shield of Alabama
PART B JURISDICTION: See Noridian Mutual Insurance Co.(North Dakota)

KANSAS PART A PROVIDER SERVICE AREA: State of Kansas
PART B JURISDICTION: States of Kansas, Western Missouri and Nebraska

BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
Street Address: 1133 Topeka Avenue
Topeka, Kansas 66629
Post Office Box 239
Topeka, Kansas 66601
PHONE: 785-291-7000
FAX: 785-291-7098
Email:bc.medicare@bcbsks.com

PART A - AGREEMENT NO. HCFA 87-001-1.19 (KANSAS)
PART B - CONTRACT NO. HCFA-87-013-2
(KANSAS) PART B - CONTRACT NO. HCFA-91-040-2 (NEBRASKA)

John W. Knack
President & CEO Kay Vondemkamp
Vice President
Government Programs
PHONE: 785-291-8851

David Manley
Vice President
Subscriber Services and Government
Programs
PHONE: 785-291-8772

KENTUCKY PART A PROVIDER SERVICE AREA: See State of Indiana, Anthem Insurance Companies, Inc.
PART B JURISDICTION: See State of Indiana, AdminaStar Federal, Inc.

LOUISIANA PART A PROVIDER SERVICE AREA - See Blue Cross and Blue Shield of Mississippi
PART B JURISDICTION - See Arkansas Blue Cross and Blue Shield

MAINE PART A PROVIDER SERVICE AREA: State of Maine, State of Massachusetts (SPECIAL CLAIMS: HHA, Provider-Based HHA/Hospice, RHC)

PART B JURISDICTION - See National Heritage Insurance Company

ANTHEM HEALTH PLANS OF MAINE, INC.
2 Gannett Drive South
Portland, Maine 04106-6911
PHONE: 207-822-7000
FAX: 207-822-7926 INTERNET:Medicare@bcbsme.com
PART A- AGREEMENT NO. HCFA 87-001-1.22

James Parker
Vice President and General Manager

Donald Sirois
Executive Director of Government Programs
Phone: 207-822-8946
FAX: 207-822-7926

Richard Haggerty
Medicare Coordinator
Phone: 207-822-7093
FAX: 207-822-7375

Edward J. Kane
Senior Vice President
Legal & Federal Affairs

Field Office Part A
Robert Baroutas, Director
Massachusetts Medicare
Audit Reimbursement Department
50 Salem Street, Building A, 2nd Floor
Lynnfield, Massachusetts 01940-2694

MARYLAND PART A PROVIDER SERVICE AREA: States of Maryland and the District of Columbia
PART B JURISDICTION - See TrailBlazer Health Enterprises, LLC

CAREFIRST OF MARYLAND, INC.
(d.b.a Blue Cross and Blue Shield of Maryland, Inc.)
10455 Mill Run Circle
Owings Mills, Maryland 21117
PHONE: 410-252-5310
FAX:410-561-7951
INTERNET:Medicare_A@bcbsmd.com
PART A - AGREEMENT NO. HCFA 87-001-1.23
PART B - CWFH-HCFA-94-001-2

Mr. William L. Jews
President & CEO
PHONE: 410-998-5252 Stephan W. Simms
Director of Intermediary Operations
PHONE: 410-561-4270

MASSACHUSETTS PART A PROVIDER SERVICE AREA: See Associated Hospital Service of Maine
PART B JURISDICTION: See National Heritage Insurance Company

MICHIGAN PART A PROVIDER SERVICE AREA - See: Blue Cross and Blue Shield United of Wisconsin
PART B JURISDICTION - See Wisconsin Physicians Service Insurance Corporation

MINNESOTA PART A PROVIDER SERVICE AREA: See Noridian Mutual Insurance Company
PART B JURISDICTION: See Wisconsin Physicians Service

MISSISSIPPI PART A PROVIDER SERVICE AREA: States of Mississippi, Louisiana, and Missouri
PART B JURISDICTION - See Blue Cross and Blue Shield of Alabama

BLUE CROSS AND BLUE SHIELD OF MISSISSIPPI
(d.b.a. TriSpan Health Services)
Medicare Part A Intermediary
P.O. Box 23035
Jackson, Mississippi 39225-3046
(STREET ADDRESS)
3545 Lakeland Drive
Jackson, Mississippi 39232
PHONE: 601-936-0105
FAX: 601-664-4214
INTERNET: trispan@bcbsms.com

PART A - AGREEMENT NO. HCFA 87-001-1.27

Richard J. Hale
President & CEO

William V. Morris III
Vice President
Government Programs
PHONE: 601-664-4570
FAX: 601-664-4214

Mr. Launnie Ginn
Executive Vice President
Government Programs and
Benefits Administration
PHONE: 601-664-4546

MISSOURI PART A PROVIDER SERVICE AREA - See Blue Cross and Blue Shield of Mississippi and Mutual of Omaha Ins. Co.
PART B JURISDICTION - See Blue Cross and Blue Shield of Kansas, Inc. for Western Missouri and Arkansas Blue Cross Blue Shield for Eastern Missouri

MONTANA PART A PROVIDER SERVICE AREA: State of Montana
PART B JURISDICTION: State of Montana

(PART A)
P.O. Box 5017
Great Falls, Montana 59403
STREET ADDRESS:
3360 Tenth Avenue, South
Great Falls, Montana 59403
PHONE: 406-791-4000 (Direct Dial)
FAX: 406-727-9355
INTERNET:ndrazich@mcn.net
(PART B)
P.O. Box 4310
340 North Last Chance Gulch
Helena, Montana 59604
FAX: 406-442-9968
INTERNET:Marlene_Longfellow@bcbsmt.com

PART A - AGREEMENT NO. HCFA 87-001-1.30
PART B - CONTRACT NO. HCFA-87-018-2

Terry Screnar
President & CEO
PHONE:406-444-8200
FAX: 406-447-8607

Dave Pfeifle
Medicare A Team
Leader/Audit Manager
Supervisor
Phone: 406-791-4152

Lana Finch
Manager
Customer Relations
& Operations
PHONE: 406-444-8503

Medicare B Receptionist
PHONE: 406-447-8713 J

Peter J. Babin
Executive Vice President
and Chief Operating
Officer
PHONE:406-444-8200
FAX:406-447-8607

Shirley Carlson
Part A Medicare Claims
Phone: 406-791-4087

Mike Wagner
Vice President
Federal Programs
Medicare A & B
Medicare Coordinator)
PHONE: 406-791-4152-
Part A
PHONE: 406-444-8356-
Part B

(Janet Whitmoyer
Manager
Medical Benefits & Fraud
PHONE:406-444-8955

NEBRASKA PART A PROVIDER SERVICE AREA: State of Nebraska
PART B JURISDICTION - See Blue Cross and Blue Shield of Kansas, Inc.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA
P.O. Box 3248, Main Post Office Station
Omaha, Nebraska 68180
STREET ADDRESS:
7261 Mercy Road
Omaha, Nebraska 68124
PHONE: 402-390-1850 (Direct Dial)
FAX: 402-398-3640 (Corporate Office)
PART A - AGREEMENT NO. HCFA 87-001-1.31

Richard L. Guffey
President

Duane Wilson
Treasurer and Chief
Financial Officer

Jerry A. Feilmeier
Director of Government
Programs
PHONE: 402-398-3824
FAX: 402-398-3640

NEVADA PART A PROVIDER SERVICE AREA - See Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION - See Nordian Mutual Insurance Company

NEW HAMPSHIRE PART A PROVIDER SERVICE AREA: States of New Hampshire and Vermont
(SPECIAL CLAIMS: RHC)
PART B JURISDICTION - See National Heritage Insurance Company

ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC.
(d.b.a. Anthem Blue Cross and Blue Shield of New Hampshire)
3000 Goffs Falls Road
Manchester, New Hampshire 03111-0001
PHONE: 603-695-7000
FAX: 603-695-7741 (notify recipient of fax)

PART A - AGREEMENT NO. HCFA 87-001-1.32

Gray Somers
Vice President and General Manager
PHONE: 603-695-7806

Donald Sirois
Executive Director of Government Programs
PHONE: 207-822-8946

David R. Hanchett
Director
Operations Division
Government Programs
PHONE: 603-695-7400
FAX: 603-695-7741

NEW JERSEY PART A PROVIDER SERVICE AREA: See Blue Cross Blue Shield of Tennessee (d.b.a. Riverbend Government Benefits Administrators)
PART B JURISDICTION - See Empire HealthChoice, Inc.

NEW MEXICO PART A PROVIDER SERVICE AREA: See Texas - TrailBlazer Health Enterprises, LLC
and Blue Cross and Blue Shield of South Carolina (HHA claims only)
PART B JURISDICTION - See Arkansas Blue Cross and Blue Shield A Mutual Insurance Company

NEW YORK PART A PROVIDER SERVICE AREA: States of New York, Delaware and Connecticut
PART B JURISDICTION: Counties of Bronx, Columbia, Delaware, Duchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester. (Also - See HealthNow New York Inc. and Group Health Incorporated)

EMPIRE HEALTHCHOICE, INC.
(d.b.a. Empire Medicare Services)

PART A - AGREEMENT NO. HCFA 87-001-1.38
PART B - CONTRACT NO. HCFA 87-021-2

Michael A. Stocker, M.D.
CEO

David B. Snow, Jr.
President

David Jaspen
Assistant Vice President
Medicare Quality Assurance and Coordination

William Foley
Vice President
Medicare Services
2651 Strang Blvd.
Yorktown Heights, NY 10598
PHONE:914-248-2852
FAX: 914-248-2948

Sally Wood
Assistant Vice President
Empire Medicare Services
New Jersey Part B Operations
300 East Park Drive
Harrisburg, PA 17111

Gloria McCarthy
Senior Vice President
Operations

NEW YORK PART B JURISDICTION: The State of New York (except for the Counties served by Empire HealthChoice, Inc. and Group Health, Inc.)

DME REGIONAL CARRIER: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Pennsylvania (PE)

HEALTHNOW NEW YORK, INC.
1901 Main Street
Buffalo, New York 14208
P.O. Box 80
Buffalo, New York 14240-0008

UPSTATE MEDICARE DIVISION OPERATIONS
33 Lewis Road
P.O. Box 5236
Binghamton, New York 13905-5236
PHONE: 716-887-6900 (Buffalo)
FAX: 716-887-8548 (Buffalo) or 607-766-6395 (Medicare)
INTERNET:
PART B - CONTRACT NO. HCFA 87-022-2
DMERC: 01-AGG-2000

Thomas P. Harnett, Ph.D.
President
1901 Main Street
PHONE: 716-887-6948

Mr. George L. Busch
Vice President, Finance
1901 Main Street
PHONE: 716-887-8822

Alphonso O'Neil-White
Vice President
General Counsel and Corporate Secretary
PHONE: 716-887-7550

William Wickis
Vice President and Chief Operating Officer
Upstate Medicare Division
PHONE: 607-766-6325

DMERC
Healthnow New York Inc.
Upstate Medicare
Division Operations
33 Lewis Road
P.O. Box 5236
Binghamton, NY 13905-5236

NORTH CAROLINA PART A PROVIDER SERVICE AREA: See Blue Cross and Blue Shield of South Carolina
PART B JURISDICTION - See Connecticut General Life Insurance Company

NORTH DAKOTA PART A PROVIDER SERVICE AREA: State of North Dakota, Minnesota
PART B JURISDICTION: States of North Dakota, South Dakota, Wyoming, Colorado, Northern Marianna Islands, American Samoa, Guam, Washington, Hawaii, Oregon, Alaska, Arizona, Nevada

NORIDIAN MUTUAL INSURANCE COMPANY
4305 13th Avenue, S.W.
Fargo, North Dakota 58103
PHONE: 701-282-1100
FAX: 701-282-1002
www.noridian.com/medweb

PART A - AGREEMENT NO. HCFA 87-001-1.44
PART B - CONTRACT NO. HCFA 87-023-2

Michael Unhjem
President & CEO

Jay Martinson
Vice President
PHONE: 701-282-1439

OHIO PART A PROVIDER SERVICE AREA: See State of Indiana, Anthem Insurance Companies Inc.
PART B JURISDICTION - See Nationwide Mutual Insurance Company

OKLAHOMA PART A PROVIDER SERVICE AREA: State of Oklahoma
PART B JURISDICTION - See Arkansas Blue Cross and Blue Shield a Mutual Insurance Company

GROUP HEALTH SERVICE OF OKLAHOMA, INC.
(d.b.a. BLUE CROSS AND BLUE SHIELD OF OKLAHOMA)
1215 South Boulder Avenue
Tulsa, Oklahoma 74119
PHONE: 918-560-3000
FAX: 918-560-3506
INTERNET:medicare@bcbsok.COM
PART A - AGREEMENT NO. HCFA 87-001-1.52

Ronald F. King
President, CEO
PHONE: 918-560-2195

Ms. Garoldine Webb
Vice President and Director of Government Programs
PHONE: 918-560-2090

OREGON PART A PROVIDER SERVICE AREA: States of Oregon, Idaho and Utah, also Clark County in the State of Washington
PART B JURISDICTION - See Noridian Mutual Insurance Company

BLUE CROSS BLUE SHIELD OF OREGON
FOR OVERNIGHT DELIVERY
1600 S.W. 4th Avenue
Portland, Oregon 97201

REGENCE BLUECROSS BLUESHIELD OF OREGON
100 S.W. Market Street
Portland, Oregon 97201
OR
P.O. Box 8110
Portland, Oregon 97207-8110
PHONE: 503-721-7116
FAX: 503-228-3304

INTERNET: MEDICARENW@REGENCE.COM

PART A -AGREEMENT NO. HCFA 87-001-1.53
CWFH - CONTRACT NO. HCFA 89-330-2

Mr. Mark Ganz
President & CEO
P.O. Box 1271
Portland, Oregon 97201-1271
PHONE: 503-226-8721
FAX: 503-225-4800

Daniel J. Mallea
Senior Vice President
Internal Operations
P.O. Box 1271
Portland, Oregon 97201-1271
PHONE: 503-225-4866
FAX: 503-225-4800

James E. Verdick
Vice President
Medicare Northwest
P. O. Box 8110
Portland, Oregon 97207-8110
PHONE: 503-721-7115
FAX: 503-228-3304

PENNSYLVANIA PART A PROVIDER SERVICE AREA: Pennsylvania (SPECIAL CLAIMS: RHC).

HIGHMARK INC.
(d.b.a. Veritus Medicare Services)
120 Fifth Avenue, Suite P5101
Pittsburgh, Pennsylvania 15222-3099
PHONE: 412-544-7000
FAX: 412-544-8054
INERNET: veritusmedicare@highmark.com
Beneficiary Calls Only: 1-800-853-1419
Web Address: www.veritusmedicare.com

PART A - AGREEMENT NO. HCFA 87-001-1.5

John S. Brouse
President & CEO
Highmark Inc.
PHONE: 412-544-8202

George F. Grode
Executive Vice President
Government Business Corp. Affairs
PHONE:412-544-8870-Pittsburgh
PHONE:717-763-6568-Camphill

Robert C. Gray
Senior Vice President
Chief Financial Officer & Treasurer of Finance
Highmark, Inc.
Camphill, PA
PHONE: 717-763-6274

Address all technical and procedural correspondence to:
Senior Vice President
Government Business Unit
120 Fifth Avenue
Suite P5101
Pittsburgh, PA 15222-3099
PHONE: 412-544-1961
FAX: 412-544-1971

PENNSYLVANIA PART B JURISDICTION: State of Pennsylvania

HIGHMARK INC.
(d.b.a. HGSAdministrators)
P.O. Box 890065
Camp Hill, Pennsylvania 17089-0065
FOR EXPRESS MAIL:
1800 Center Street
Camp Hill, Pennsylvania 17089
PHONE: 717-763-3151 (Center Street) FAX: 717-975-7045 (Center Street)
INTERNET:hgsa@hgsa.com

PART B - CONTRACT NO. HCFA 87-025-2

John S. Brouse
President & CEO
Highmark Inc.
PHONE: 717-763-3354

George F. Grode
Executive Vice President
Government Business
Corp. Affairs
PHONE:412-544-8870

Patrick M. Kiley
Vice President
HGS Administrators
PHONE: 717-730-5891

Robert Gray
Senior Vice President
Chief Financial Officer & Treasurer of Finance
Camphill, PA
PHONE: 412-544-8043

Andrew Bloschichak, M.D. MBA
Vice President
Medical Affairs & Medical Director
HGS Administrators
PHONE: 717-760-9516

PUERTO RICO PART A PROVIDER SERVICE: See Cooperativa de Seguros de Puerto Rico

PART B JURISDICTION: Puerto Rico and U.S. Virgin Islands

TRIPLE-S, INC.
Box 71391
San Juan, Puerto Rico 00936-1391
STREET ADDRESS:
1441 F.D. Roosevelt Avenue
Caparra, Puerto Rico 00920
PHONE: 787-749-4949 (Switch Board)
PHONE: 787-749-4083 (Medicare)
FAX: 787-749-4092
INTERNET: Glebrón@triples-med.org

PART B- CONTRACT NO. HCFA 87-033-2

Miguel Vázquez-Deynes
President and Chief Executive Officer
PHONE: 787-749-4114
FAX: 787-749-4191

Carlos Gonzales, Esq.
Assistant Vice President
Medicare
PHONE: 787-749-6691
FAX: 787-749-4092

Mrs. Socorro Rivas
Executive Vice President and General Manager
PHONE: 787-749-4118
FAX: 787-749-4191

Gloria Lebrón, Esq.
Vice President, Medicare
PHONE: 787-749-4083
FAX: 787-749-4092

RHODE ISLAND PART A PROVIDER SERVICE AREA: State of Rhode Island
PART B JURISDICTION: State of Rhode Island

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND
444 Westminster Street
Providence, Rhode Island 02903-3279
PHONE: 401-459-1000
FAX: 401-459-1709
INTERNET: MARROCCO.C@BCBSRI2.ORG
PART A - AGREEMENT NO. HCFA 87-001-1.58
PART B - CONTRACT NO. HCFA 87-026-2

Ronald Battista
President
PHONE: 401-459-1200

John V. Griffin
Medicare Administrator

Cathy Sullivan
Assistant Administrator

John Lynes
Assistant Vice President
Government Programs
PHONE: 401-459-2501
INTERNET: LYNES.J@BCBSRI.ORG

SOUTH CAROLINA PART A PROVIDER SERVICE AREA: State of South Carolina and North Carolina
(SPECIAL CLAIMS:HHA, Hospices)
PART B JURISDICTION: State of South Carolina
DME REGIONAL CARRIER: Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, (PE)

Statistical Analysis Durable Medical Equipment Carrier (SADMERC)

National Supplier (NSC) Clearinghouse

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
17 Technology Circle
Columbia, South Carolina 29203-9511
PHONE: 803-788-0222 FAX: 803-935-0081
INTERNET: ROSE.VOYLES@PalmettoGBA.COM

PART A - AGREEMENT NO. HCFA 87-001-1.59

William R. Horton
President
I-20 at Alpine Road
Columbia, SC 29219
PHONE: 803-788-4138
FAX: 803-736-9289

Bruce W. Hughes
Executive Vice President
Chief Operating Officer
17 Technology Circle
Mail Code: AG-A03
Columbia, SC 29203-9511
PHONE: 803-763-7130
Columbia, SC 29223
FAX: 803-935-0081

Roz Catoe
Vice President
Medicare Processing & Customer Service
17 Technology Circle
Mail Code: AG-G05
Columbia, SC 29202-9511
PHONE: 803-763-5086
FAX: 803-935-0176

Sue Pearcy
Vice President
Medicare Integrity/Audit & Reimbursement
17 Technology Circle
Mail Code: AG-A11
Columbia, SC 29203-9511
PHONE: 803-763-5545
FAX: 803-935-0176

Ann Archibald
Vice President
Medicare Administration/Compliance
17 Technology Circle
Mail Code: AG-A02
Columbia, SC 29202-9511
PHONE: 803-763-8700
FAX: 803-935-0081

Dickie Butler
Vice President
Systems/EDI
17 Technology Circle
Mail Code: AG-A08
Columbia, SC 29203-9511
PHONE: 803-763-1077
FAX: 803-935-1411

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
(d.b.a. PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS)
EXECUTIVE OFFICES
17 Technology Circle
Columbia, South Carolina 29203-9511
OPERATIONS OFFICES:
P.O. Box 100190
Columbia, SC 29202-3190
PHONE: 803-736-8128
FAX: 803-935-0081
INTERNET: ROSE.VOYLES@Palmettogba.com
INTERNET-DMERC: ROSE.VOYLES@Palmettogba.com
PART B - CONTRACT NO. HCFA 87-027-2
PART B - CONTRACT - RRB
DMERC - CONTRACT NO. HCFA 500-93-BPO-3

William R. Horton
President
I-20 at Alpine Road
Columbia, SC 29219
PHONE: 803-788-4138
FAX: 803-736-9289

Bruce W. Hughes
Executive Vice President
and Chief Operating Officer
17 Technology Circle
Mail Code: AG-A03
Columbia, SC 29203-9511
PHONE: 803-863-7130
FAX: 803-935-0081

Roz Catoe
Vice President
Medicare Processing &
Customer Service
17 Technology Circle
Mail Code: AG-A05
Columbia, SC 29202-9511
PHONE: 803-763-5086
FAX: 803-935-0176

Sue Pearcy
Vice President
PHONE: 803-763-5545
FAX: 803-935-0176

Dickie Butler
Vice President
Systems/EDI
17 Technology Circle
Mail Code: AG-A08
Columbia, SC 29203-9511
PHONE: 803-763-3107
FAX: 803-935-1411

Mike Barlow
Assistant Vice President
Railroad Medicare
2743 Perimeter Parkway
Building 200, Suite 400
Augusta, GA 30909
PHONE: 706-855-3130
FAX: 706-855-3132

Durable Medical Equipment
Robin Spires
Assistant Vice President
NSC/SA DMERC & Medicare Admin.
17 Technology Circle
Columbia, SC 29203
PHONE: 803-788-0222
FAX: 803-935-0081

SOUTH DAKOTA - PART A PROVIDER SERVICE AREA - See Blue Cross and Blue Shield of Alabama
PART B JURISDICTION- See North Dakota, Noridian Mutual Insurance Company

TENNESSEE PART A PROVIDER SERVICE AREA: State of Tennessee, New Jersey (SPECIAL CLAIMS: RHC, CSC, OPT, HL, LPIC)
PART B JURISDICTION - See Connecticut General Life Insurance Company

BLUE CROSS BLUE SHIELD OF TENNESSEE
(d.b.a. Riverbend Government Benefits Administrator)
801 Pine Street
Chattanooga, Tennessee
37402
Medicare Address: 730 Chestnut Street Chattanooga, TN 37402
PHONE:423-755-5955 (Medicare Beneficiary)
Provider Line: 877-296-6189 (toll free)
FAX: 423-752-6518
INTERNET:sharon_cheek@bcbst.com

PART A - AGREEMENT NO. HCFA 87-001-1.60

Thomas Kinser
President & CEO

Ann Keown
Vice President

David Jackson
Director
Government Programs
Medicare Integrity Program and
Reimbursement
Phone:423-755-5783

TEXAS PART A PROVIDER SERVICE AREA: State of Texas, New Mexico and Colorado
PART B JURISDICTION: States of Texas, Maryland, Delaware, District of Columbia, City of Alexandria, Arlington and Fairfax Counties in Virginia (Special Claims: RHC), Virginia

TRAILBLAZER HEALTH ENTERPRISES, LLC
P.O. Box 660156
Dallas, Texas 75266-0156
STREET ADDRESS:
8330 LBJ Freeway
Executive Center 3
Dallas, Texas 75243
PHONE: 972-766-6900
FAX: 972-766-1765
INTERNET-TX: tb.mail@trailblazerhealth.com
PART A - AGREEMENT NO. HCFA 87-001-1.62
PART B - CONTRACT NO. HCFA 87-029-2

Ms. Marti Mahaffey
Executive Vice President and COO
PHONE: 469-372-4902

UTAH PART A PROVIDER SERVICE AREA: See Regence Blue Cross Blue Shield of Oregon
PART B JURISDICTION: State of Utah

REGENCE BLUE CROSS AND BLUE SHIELD OF UTAH
2890 East Cottonwood Parkway
Salt Lake City, Utah 84121
OR
P.O. Box 30269
Salt Lake City, Utah 84130-0269
PHONE: 801-333-2000
FAX: 801-333-6510Z
INTERNET:veggers@Regence.com

PART B - CONTRACT NO. HCFA 87-030-2

John Ruch
Chairman, President & CEO
PHONE: 801-333-5630

James E. Verdick
Vice President
Government Programs
PHONE: 503-721-7115

John Mitchell
Assistant Vice President
Medicare B
PHONE: 801-333-5225

VERMONT PART A PROVIDER SERVICE AREA - See New Hampshire-Vermont HealthService
PART B JURISDICTION - See National Heritage Insurance Company

VIRGINIA PART A PROVIDER SERVICE AREA: See Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION - TrailBlazer Health Enterprises, LLC

WASHINGTON PART A PROVIDER SERVICE AREA: States of Washington and Alaska
PART B JURISDICTION - See Blue Cross Blue Shield of North Dakota

PREMERA BLUE CROSS
P.O. Box 2847
Seattle, Washington 98111-2847
STREET ADDRESS:
7001 - 220TH S.W.
Mountlake Terrace, Washington 98043
PHONE: 877-602-7896
FAX: 425-670-5505
INTERNET:kathleen.henderson@premera.com

PART A - AGREEMENT NO. HCFA 87-001-1.66

H.R. Brerton (Gubby) Burlow President & CEO PHONE: 425-670-4738	Judy Ellis Vice President Production Administration PHONE: 425-670-5657	Janet Russell Director Federal Programs PHONE: 425-670-5504

WEST VIRGINIA PART A PROVIDER SERVICE AREA- See Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION - See Nationwide Mutual Insurance Company

WISCONSIN PART A PROVIDER SERVICE AREA: States of Wisconsin, Michigan, Virginia, West Virginia, California, Nevada, Guam, Northern Mariana Islands and American Samoa (SPECIAL CLAIMS: HHA, Hospice, FQHC)
PART B JURISDICTION - See Wisconsin Physicians Service Insurance Corporation

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
(d.b.a United Government Services, LLC)
401 West Michigan Street
Milwaukee, Wisconsin 53203-2804
PHONE: 414-226-6203
INTERNET: www.ugsmedicare.com

Beneficiary Inquiries
Milwaukee Office 1-800-531-9695
Detroit Office 1-866-804-0686
Roanoke Office 1-877-768-5471
Camarillo Office 1-866-804-0684 (Inpatient & SNF)
1-877-602-7904 (HH/Hosp)
Provider Inquiries
Milwaukee Office: 1-877-309-4290
Detroit Office: 1-866-419-9462
Roanoke Office: 1-877-908-8474
Camarillo Office: 1-866-380-4745 (Inpatient & SNF)
1-888-539-5594 (HH/Hosp)
1-866-849-7244 (Hawaii)

PART A - AGREEMENT NO. CMS 87-001-1.70

Thomas R. Hefty
Chairman, President & CEO
Blue Cross and Blue Shield United of Wisconsin
PHONE: 414-226-6295

Sally T. Wood
Vice President, Program Management
United Government Services, LLC.
Phone: 414-226-2813

Sandy Coston
President, United Government Services, LLC.
PHONE: 414-226-5588

Cheryl Leissring
Compliance Officer
United Government Services, LLC.
Phone: 414 226-5884

Jorge Gomez
Vice President, Legal, Audit and Compliance
United Government Services, LLC.
Phone: 414-226-6947

Timothy F. Cullen
Chairman, United Government Services, LLC
PHONE: 414-226-6004

Todd Reiger
Director of Finance
United Government Services, LLC.
Phone: 414-226-5606

Steve Holubowicz
Vice President, Program Safeguards
United Government Services, LLC.
PHONE: 414-226-6991

Janine Harris
Vice President, Medicaid and Administration
United Government Services, LLC.
PHONE: 414-226-5160

Shig Kimoto
Vice President, Information Technology
United Government Services, LLC.
Phone: 805-367-1010

WYOMING PART A PROVIDER SERVICE AREA: State of Wyoming
PART B - See Nordian Mutual Insurance Company

BLUE CROSS AND BLUE SHIELD OF WYOMING
4000 House Avenue
Cheyenne, Wyoming 82001
OR
P.O. Box 2266
Cheyenne, Wyoming 82003-0908
PHONE: 307-432-2860
FAX: 307-632-1654
INTERNET: Jeff.Beuchel@bcbswy.com

PART A - AGREEMENT NO. HCFA 87-001-1.71

Tim Crilly
President
Medicare Coordinator
PHONE: 307-432-3022

Jeffrey Beuchel
Director
Medicare
PHONE: 307-432-2848

SECTION III

COMMERCIAL AND INDEPENDENTS - PART A & B

COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO
GPO Box 363428
San Juan, Puerto Rico 00936-3428
STREET ADDRESS:
400 Americo Miranda Avenue
San Juan, Puerto Rico 00927
PART A - AGREEMENT NO. HCFA 87-326-1
PHONE: 787-758-9733(switchboard)
FAX: 787-756-8199

PART A PROVIDER SERVICE AREA: Puerto Rico and U.S. Virgin Islands

Mr. Carlos Fernández
President
PHONE: 787-758-7854

Jose A. Brull
Vice President, Medicare
PHONE: 787-763-2053

Ms. Alba Cosme
Assistant Vice President
Audit and Reimbursement
PHONE: 787-758-8615

Mrs. María T. Mejías
Assistant Vice President
Medicare Operations
PHONE: 787-765-2570

CONNECTICUT GENERAL LIFE INSURANCE COMPANY (CGLIC), a CIGNA Company
Hartford, Connecticut 06152
615-244-5600
615-782-4445

PART B - CONTRACT NO. HCFA 91-330-2
DMERC - CONTRACT No. 50093BPOO4

PART B JURISDICTION: States of Idaho, North Carolina, Tennessee
DME REGIONAL CARRIER: Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming (PE)

Mr. Edward H. Burrell
Vice President, CIGNA HealthCare Medicare Administration Customer Service Center
2 Vantage Way
Nashville TN 37228
PHONE: 615-782-4571
FAX: 615-782-4695
Ed.Burrell@cigna.com

CLAIMS SYSTEMS
William Swanke
Systems Director
2 Vantage Way
Nashville, TN 37228
PHONE: 615-782-4672
FAX: 615-782-0187
Bill.swanke@cigna.com

DURABLE MEDICAL EQUIPMENT
Mary Moorman
2 Vantage Way
Nashville, TN 37228
PHONE: 615-782-4599
FAX: 615-782-4626
Mary.moorman@cigna.com

Idaho, Tennessee, North Carolina
Mr. John Hoey
Asst. Vice President, CIGNA HealthCare Medicare Administration Customer Service Center
2 Vantage Way
Nashville, TN 37228
PHONE: 615-782-4484
FAX:615-782-4473
John.hoey@cigna.com

Darrell Tackett
Director of Claims and Technology
2 Vantage Way
Nashville TN 37228
PHONE: 615-782-4525
FAX: 615-782-4627
Darrell.tackett@cigna.com

Beverly Redd
Director of HealthCare Integrity
2 Vantage Way
Nashville, TN 37228
PHONE: 615-782-4617
FAX: 615-782-4446
Beverly.redd@cigna.com

Brian Setzer
Director of Finance and Compliance
2 Vantage Way
Nashville, TN 37228
PHONE: 615-782-4618
FAX: 615-782-4622
Brian.setzer@cigna.com

GROUP HEALTH INCORPORATED
25 Broadway
New York, New York 10004
PHONE: 646-458-6600
FAX: 646-458-6761
PART B - CONTRACT NO. HCFA 87-320-2

PART B JURISDICTION: Queens County, New York

Peter S. Moore
Vice President
PHONE: 646-458-6601

Lynne Ridgeway
Assistant Vice President
PHONE: 646-458-6607

Sean Martinez
Director
Community Relations
PHONE: 646-458-6622
FAX: 646-458-6756

Jim Brandy
Director
Program Evaluation and Integrity
PHONE: 646-458-6682
FAX: 646-458-6764

HAWAII MEDICAL SERVICE ASSOCIATION

PART A PROVIDER SERVICE AREA: See Blue Cross Blue Shield United of Wisconsin
PART B JURISDICTION: See North Dakota - Noridian Mutual Insurance Company

UNITED HEALTH CARE INSURANCE COMPANY

PART A PROVIDER SERVICE AREA: See Empire HealthChoice, Inc. and Blue Cross and Blue Shield United of Wisconsin
PART B JURISDICTION: See Blue Cross and Blue Shield of Florida (Connecitut), See Wisconsin Physicians Services (Minnesota), See Blue Cross and Blue Shield of Alabama (Mississippi), See TrailBlazer Health Enterprises, LLC (Virginia) - DME Reg. Carrier, See HealthNow New York Inc.

MUTUAL OF OMAHA INSURANCE COMPANY
P.O. Box 1602
Omaha, Nebraska 68131-3492
STREET ADDRESS:
Mutual of Omaha Plaza
Omaha, Nebraska 68175
PHONE: 402-351-2860
FAX: 402-351 8047
INTERNET: WWW.MUTUALMEDICARE.COM

PART A - AGREEMENT NO. HCFA 87-319-1

PART A PROVIDER SERVICE AREA: Available in all states

Rick Reeves
Vice President and Director of Medicare
P.O. Box 1602
Omaha, NE 68101
PHONE: 402-351-2940
FAX: 402-351-8796
EMAIL: RICK.REEVES@MUTUALOFOMAHA.COM

Elizabeth M. Powers
First Vice President
Medicare Admin. Systems
P.O. Box 1602
Omaha, NE 68101
PHONE: 402-351-2570
FAX: 402-351-5931
EMAIL: LIZ.POWERS@MUTUALOFOMAHA.COM

Shelly Foxworthy
First Vice President Audit & Reimbursement
P.O. Box 1604
Omaha, NE 68101
PHONE: 402-351-5377
FAX: 402-351-8796
EMAIL: SHELLY.FOXWORTHY@MUTUALOFOMAHA.COM

Patricia Allmon
First Vice President
Medicare Claims Program
Mutual of Omaha Ins. Co.
P.O. Box 1602
Omaha, NE 68101
PHONE: 402-351-3205
FAX: 402-351-5931
EMAIL: TRISH.ALLMON@MUTUALOFOMAHA.COM

Les Peterson
First Vice President
Medicare Program Integrity
Mutual of Omaha Ins. Co. P.O. Box 1602
Omaho, NE 68101
PHONE: 402-351-2268
FAX: 402-351-5931
EMAIL: LES.PETERSON@MUTUALOFOMAHA.COM

MUTUAL OF OMAHA FIELD OFFICES
DENVER, CO
Rick Keegan
Field Audit Manager
Panorama Corporate Center V
9200 E Panorama Circle
Suite 225
Englewood, CO 80112-3481
PHONE: 302-925-0065
FAX: 302-925-0869
EMAIL: RICK.KEEGAN@MUTUALOFOMAHA.COM

SACRAMENTO, CA
Dan Dahl
Field Audit Manager
Capital Professional Center
2200 B Douglas Blvd.
Suite 275
Roseville, CA 95661
PHONE: 916-774-9275
FAX: 916-774-1112
EMAIL: DAN.DAHL@MUTUALOFOMAHA.COM

LOS ANGELES, CA
Richard N. Eclarin
Field Audit Manager
901 Corporate Center Drive
Suite 405
Monterey Park, CA 91754
PHONE: 323-881-9586
FAX: 323-881-9534
EMAIL: RICK.ECLARIN@MUTUALOFOMAHA.COM

DALLAS, TX
Neil A. Milbrandt
Field Audit Manager
14200 Midway Road
Suite 125
Dallas, TX 75244
PHONE: 972-386-4061
FAX: 972-233-9406
EMAIL: NEIL.MILBRANDT@MUTUALOFOMAHA.COM

KANSAS CITY,MO
Marilyn Huskamp
Field Audit Manager
10220 North Executive Hills Blvd.
Suite 220
Kansas City, MO 64153
PHONE: 816-891-6500
FAX: 816-891-8817
EMAIL: MARYLIN.HUSKAMP@MUTUALOFOMAHA.COM

ST. LOUIS, MO
Mike Connelly
Field Audit Manager
11701 Borman Drive
Suite 220
St. Louis, MO 63146-4193
PHONE: 314-997-6626
FAX: 314-997-6997
EMAIL: MIKE.CONNELLY@MUTUALOFOMAHA.COM

CLEARWATER, FL
Cynthia MacDonald
Field Audit Manager
33920 U.S. Highway 19 North, Suite 360
Palm Harbor, FL 34684
PHONE: 727-772-2557
FAX: 727-772-7193
EMAIL: CYNTHIA.MACDONALD@MUTUALOFOMAH.COM

ATLANTA, GA
Linda Smallwood
Field Audit Manager
2400 Herodian Way
Suite 300
Smyrna, GA 30080
PHONE: 770-988-9052
FAX: 770-988-9065
EMAIL: LINDASMALLWOOD@MUTUALOFOMAHA.COM

CHICAGO, IL
Art Garvida
Field Audit Manager
377 East Butterfield Road
Suite 260
Lombard, IL 60148
PHONE: 630-810-1324
FAX: 630-810-1368
EMAIL: ART.GARVIDA@MUTUALOFOMAHA.COM

HARFORD, CT
Gerge PietrI
Field Audit Manager
655 Winding Brook Dr.
Glastonbury, CT 06033
PHONE: 860-659-4300
FAX: 860-659-8065
EMAIL: GEORGE.PIETRI@MUTUALOFOMAHA.COM

NATIONAL HERITAGE INSURANCE COMPANY
402 Otterson Drive
Chico, CA 95928
PHONE: 530-634-7000
FAX: 530-896-7182
INTERNET: NHICMEDICARE@EDS.COM

CALIFORNIA (Northern)
Beneficiary Services - 800-952-8627
Provider Services - 877-591-1587

(All counties except San Luis Obispo, Santa Barbara, Ventura, Los Angeles, Orange, San Diego and Imperial)

CALIFORNIA (Southern)
Beneficiary Services - 800-675-2266
Provider Services - 866-502-9054

(For the counties of San Luis Obispo, Santa Barbara, Ventura, Los Angeles, Orange, San Diego and Imperial)

MAINE
Beneficiary Services - 800-492-0919
Provider Services - 877-567-3129

MASSACHUSETTS
Beneficiary Services - 800-882-1228
Provider Services - 877-567-3130

NEW HAMPSHIRE/VERMONT
Beneficiary Services - 800-447-1142
Provider Services - 866-539-5595
PART B - CONTRACT NO. HCFA-96-331-2

PART B JURISDICTION: State of California (South): San Luis Obispo, Los Angeles, Ventura, San Diego, Santa Barbara, Orange and Imperial Counties - See States of Maine, Massachusetts, New Hampshire, Vermont, Illinois, and Michigan (claims processing) - See after 12/1/2000 Whole State of California

NHIC

Matthew W. Chambers
General Manager
Client Delivery Executive
Claims Processing Solutions
Business Process Management
EDS - Mail Stop A1-1A-18
Herdon, VA 20171
5400 Legacy Drive
Plano, TX 75024
PHONE: 972-604-7087

Donald S. Picard
Vice President, Medicare
Mailstop A5N-C47
13600 EDS Drive
Herdon, VA 20171
PHONE: 703-742-2280
FAX: 703-742-2886

Jeffery T. Broocks
Client Delivery Executive
NHIC
402 Otterson Drive
Chico, CA 95928
PHONE: 530-896-7081
FAX: 530-896-7182

Karen Horton
Administrative Assistant
402 Otterson Drive
Chico, CA 95928
PHONE: 530-896-7025
FAX: 530-896-7182

Anne Bockhoff Dalton
Account Delivery Executive
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3201
FAX: 781-741-3211

Lynn Gillespie
Administrative Assistant
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3195
FAX: 781-741-3211

Paul Ackerman
Technology Support Director
NHIC-B311
1055 West 7th Street
Los Angeles, CA 90017
PHONE: 213-593-6192
FAX: 213-595-5900

Andrew Conn
Claims Operations Director
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3029
FAX: 781-741-3032

Robert Harrington
Program Safeguards Director
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3255
FAX: 781-741-3083

Jane Hite
Program Administration Director
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3401
FAX: 781-741-3211

Lola Jordan
Customer Service Director
NHIC
620 J. Street
Marysville, CA 95901
PHONE: 530-634-7451
FAX: 530-634-7443

Gerald Rogan, MD FACEP
Western Region Medical Director
NHIC
402 Otterson Drive
Chico, CA 95928
PHONE: 530-896-7123

Charlotte S. Yeh, MD
Eastern Region Medical Director
NHIC
75 Sgt. William Terry Drive
Hingham, MA 02043
PHONE: 781-741-3122
FAX: 781-741-3211

Dr. Arthur Lurvey
1055 West 7th Street
Los Angeles, CA 90017
PHONE: 213-593-6192
FAX: 213-593-5921
FAX: 530-896-7162

NATIONWIDE MUTUAL INSURANCE COMPANY - NOTE: Learning Program 7/1/02 - replacement is Blue Cross and Blue Shield of South Carolina
Medicare Operations
P.O. Box 182948
Columbus, Ohio 43218-2948
Street Address: 3400 South Park Place
Suite F
Grove City, Ohio 43123-4846
800-282-0530 (Ohio Beneficiaries)
800-848-0106 (West Virginia Beneficiaries)
800-542-5250 (TTD for Ohio and West Virginia Beneficiaries)
877-567-9232 (Ohio and West Virginia Providers)
888-619-5316 (Medicare Fraud Hotline)
FAX: 614-277-6806
INTERNET: Medicare@Nationwide.com
www.nationwide-medicare.com

PART B - CONTRACT NO. HCFA 87-311-2

PART B JURISDICTION: States of Ohio and West Virginia

William G. (Jerry) Jurgensen
Chairman & Chief Executive Officer
Nationwide
PHONE: 614-249-9649

Donna A. James
Executive Vice President
& Chief Administrative
Officer
Nationwide
PHONE: 614-249-2952

Kim R. Geyer
Vice President
Business Operations
PHONE: 614-277-6400
FAX: 614-277-6803

Robert R. Kamps
Medicare Medical Director
PHONE: 614-277-6424

David S. Slavik
Medicare Controller
PHONE: 614-277-6404

Mary A. Coleman
Director, Medicare Integrity Programs
PHONE: 614-277-6500

Catherine McClary
Director, Customer Service
PHONE: 614-277-6409

Carolyn McDaniels
Director, Claims
PHONE: 614-277-6402

FIELD OFFICE ADDRESS:
Tim Allman
Field Manager
P.O. Box 3183
1207 Quarrier Street
Charleston, WV 25332
PHONE: 304-346-0411

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION
ADMINISTRATION: P.O. Box 8190
Madison, Wisconsin 53708
STREET ADDRESS:
1601 Engel Street
Madison, Wisconsin 53713
PHONE: 608-221-4711
FAX: 608-301-2625
INTERNET:wps00951@madison.tds.net

PART B - CONTRACT NO. HCFA 87-032-2

PART B JURISDICTION: State of Wisconsin, Illinois, Michigan, and Minnesota

James R. Riordan
President & CEO

William Bathke
Executive Vice President
and COO

Ned Boston
Vice President
Medicare Division
PHONE: 608-301-2603

Mary Strope
Director, Customer Service
PHONE: 608-301-2605

David Horst
Director, Operations
PHONE: 608-301-2608

Lisa Sunde
Director, Program Integrity
PHONE: 608-301-2607

Sheila Bechmann
Senior Manager, Systems
PHONE: 608-301-2618
Marie Wybo
Senior Manager, Detroit Admin.
PHONE: 313-962-6312

Wisconsin Claims
P.O. Box 1787
Madison, WI 53701
PHONE: 1-877-567-7176 (Prov.)
PHONE: 1-800-944-0051 (Bene.)

Illinois Claims
P.O. Box 1030
Marion, IL 62959
PHONE: 1-877-908-9499 (Prov.)
PHONE: 1-800-642-6930 (Bene.)

Michigan Claims
P.O. Box 5555
Marion, IL 62959
PHONE: 1-877-567-7201 (Prov.)
PHONE: 1-800-482-4045 (Bene.)

Minnesota Claims
8120 Penn Avenue South
Bloomington, MN 55431
PHONE: 1-877-908-8470 (Prov.)
PHONE: 1-800-352-2762 (Bene.)

SECTION IV

REGIONAL HOME HEALTH INTERMEDIARIES
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
COMMON WORKING FILE HOST CONTRACTORS

Regional Home Health Intermediaries
Region I(*)
Anthem Health Plans of Maine, Inc. (a.b.a. Associated Hospital Service)
2 Gannett Drive
South Portland, Maine 04106-6911
Phone: 207-822-7000
Serving: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region IV(*)
Blue Cross and Blue Shield of South Carolina
I-20 at Alpine Road
Columbia, South Carolina 29219
Phone: 803-788-3860
Serving: Kentucky, North Carolina, South Carolina, Tennessee, Alabama, Florida, Georgia, Mississippi, Arkansas, Louisiana, New Mexico, Oklahoma, Texas, Illinois, Indiana, and Ohio

Region V(*)
Blue Cross and Blue Shield United of Wisconsin
d.b.a. UGS, LLC
401 West Michigan Street
Milwaukee, Wisconsin 53203-2804
Phone: 414-226-6203
Serving: Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada, Washington, Northern Mariana Islands, Guam, and American Samoa
Serving: Michigan, Minnesota, New Jersey, New York, Puerto Rico, the Virgin Islands, and Wisconsin

Region VII(*)
Blue Cross and Blue Shield of Alabama
P.O. 830139
Birmingham, Alabama 35283-0139
Phone: 205-988-2100
Serving: Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

*Designates the HCFA Region in which the intermediary is physically located.

Durable Medical Equipment Regional Carriers

Region A
HealthNow New York, Inc.
Jeanne Mariani
Director
60 E Main Street
Naticoke, PA 18634
Phone: 570-735-9400
FAX: 570-735-9402
Serving: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

Region B
Michael McCarron
President
AdminaStar Federal Inc.
8115 Knue Road
Indianapolis, Indiana 46250
Phone: 317-841-4400
FAX: 317-841-4691
Serving: District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia, West Virginia, Wisconsin

Region C
Mr. William R. Horton
Group Vice President
Blue Cross and Blue Shield of South Carolina
I-20 at Alpine Road
Columbus, South Carolina 29219
Phone: 803-735-1034
FAX: 803-786-4636
Serving: Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands

Region D
Mr. Edward Burrell
Vice President
Connecticut General Life Insurance Company
2 Vantage Way
Metro Exchange Building
Nashville, Tennessee 37228
Phone: 615-782-4511
FAX: 615-244-6242
Serving: Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa and Northern Mariana Islands

Common Working File Host Contractors

Blue Shield of Oregon
Contract #HCFA-89-330-2

Blue Shield of Maryland
Contract #HCFA-94-001-2

Blue Shield of Alabama

Blue Shield of Florida

Empire Health Choice, Inc.

TrailBlazer Health Enterprise, LLC

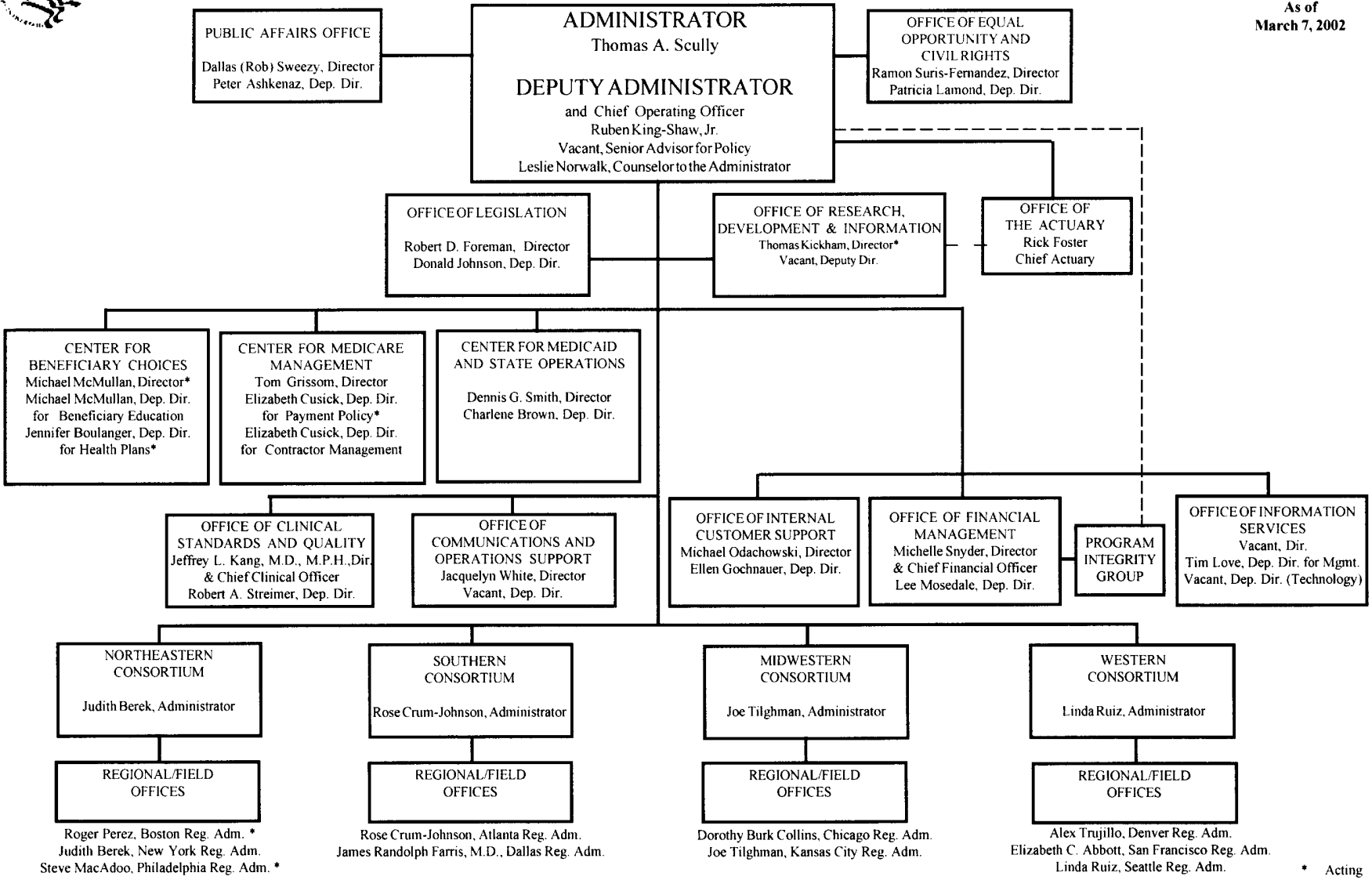
SECTION IV - RURAL HEALTH CLINICS

CONTRACTOR	JURISDICTION
Anthem Health Plans of Maine, Inc.	Maine
Anthem Health Plans of New Hampshire, Inc.	New Hampshire, Vermont
Highmark Inc.	Connecticut, Delaware, District of Columbia, New York, Pennsylvania, Puerto Rico, Rhode Island, Massachusetts, Virginia, West Virgina, Maryland, New Jersey, Virgin Islands
TrailBlazer HealthEnterprises, LLC	Colorado, Montana, North Dakota, Oklahoma, South Dakota, Utah, Wyoming, Texas, Arkansas, Louisiana, New Mexico
Blue Cross and Blue Shield of Tennessee	Kentucky, Tennessee, North Carolina, South Carolina, Mississippi, Alabama, Georgia, Florida, Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Nevada, Ohio, Oregon, Washington, Wisconsin

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP

As of March 7, 2002

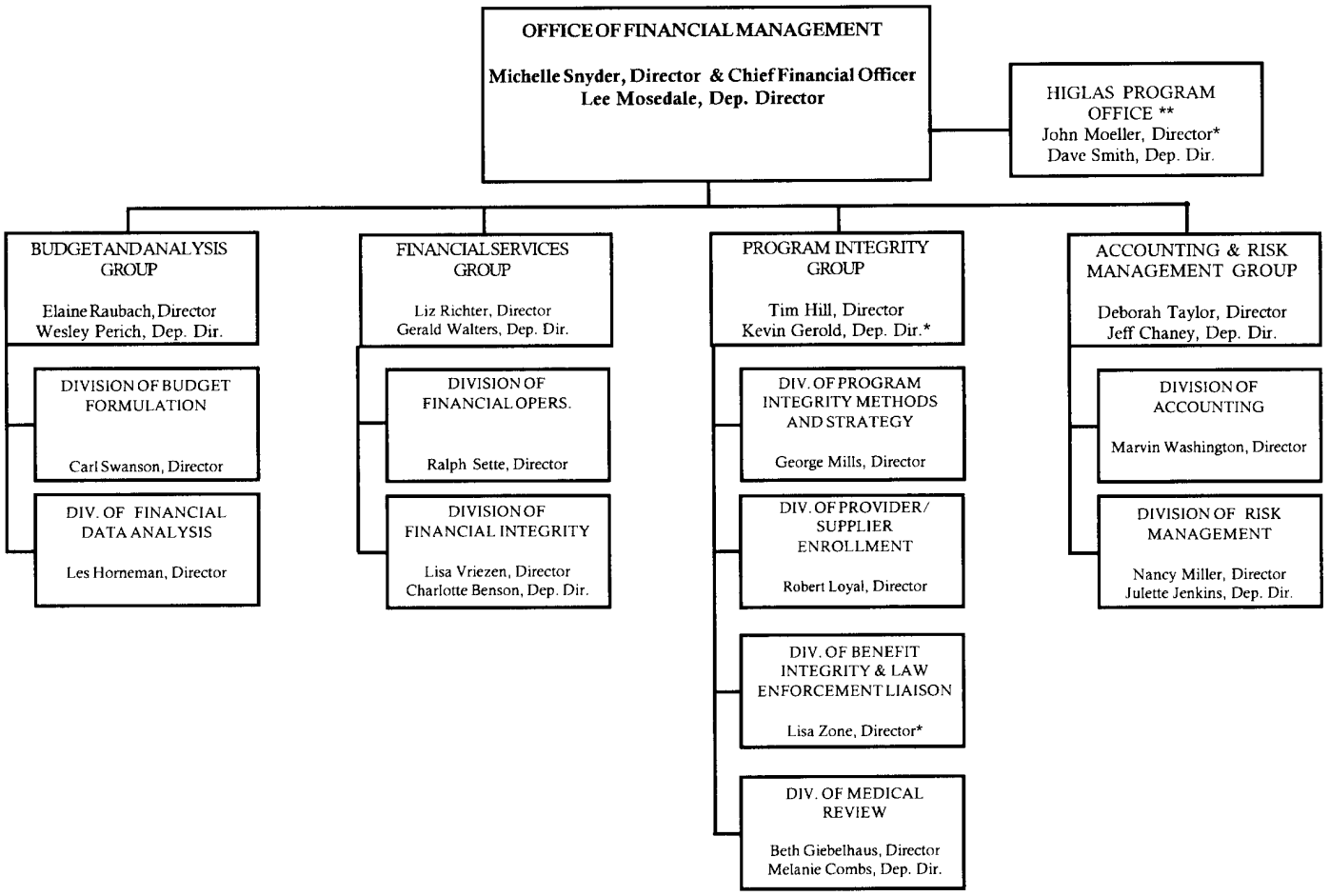


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP

As of April 1, 2002



* Acting

** Also has direct reporting relationship to OIS

HELPFUL WEBSITE ADDRESSES

from the Centers for Medicare & Medicaid Services (CMS)
Physicians' Regulatory Issues Team (PRIT)

General

Physicians' Regulatory Issues Team (PRIT)	http://www.hcfa.gov/medlearn/prithome.htm
Medicare Leaning Network	http://www.hcfa.gov/medlearn
Centers for Medicare & Medicaid Services (CMS)	http://www.hcfa.gov
Medicare Beneficiary Website	http://www.hcfa.medicare.gov
Medicare Publications for Beneficiaries	http://www.medicare.gov/Publications/Search/View/ViewPubList.asp?Language=English

** To order Beneficiary Brochures in numbers Greater Than 25, fax request to 1-410-786-1905

Press & Public Meetings

CMS Press Releases	http://www.hcfa.gov/pubaffr.htm
Practicing Physicians Advisory Council Reports Page	http://www.hcfa.gov/medicare/ppacpage.htm

Helpful Information

Advance Beneficiary Notice Frequently Asked Questions	http://www.hcfa.gov/medlearn/refabn.htm
Certificate of Medical Necessity Forms (CMNs)	http://www.hcfa.gov/medlearn/certform.htm
Eligibility Information: Telephone Inquires	http://www.hcfa.gov/pubforms/transmit/AB01137.pdf
Health Insurance Portability and Accountability Act (HIPAA)	http://www.hcfa.gov/medlearn/hipaa.htm
ICD-9-CM Coding for Diagnostic Tests	http://www.hcfa.gov/pubforms/transmit/AB01144.pdf
Key News from Medicare for Calendar Year 2002	http://www.hcfa.gov/pubforms/transmit/B0165.pdf
Medicare & Your 2002 – Special Mailing for Physicians	http://www.hcfa.gov/medlearn/physpeci.pdf
Medicare Physician, Provider, and Supplier Enrollment Applications & Information	http://www.hcfa.gov/medicare/enrollment/
Pay It Right brochure to physicians	http://www.hcfa.gov/Medicare/mip/mip/rtf
Pre-Operative Services – Basics of the provision	http://www.hcfa.gov/pubforms/transmit/R1707B3.pdf
Pre-Operative Services – Clarification	http://www.hcfa.gov/pubforms/transmit/R1719B3.pdf
Progressive Corrective Action in Medical Review	http://www.hcfa.gov/pubforms/transmit/AB0072.pdf
Verbal Orders	http://www.hcfa.gov/medlearn/verbalor.htm
Women with Medicare booklet	http://www.hcfa.gov/Publications/Pubs/pdf/women.pdf

Contacts

Carrier Toll Free Telephone Lines	http://www.hcfa.gov/medlearn/tollnums.htm
Intermediary – Carrier Directory	http://www.hcfa.gov/Medicare/incardir.htm
Regional Office for your state	http://www.hcfa.gov/regions/ro_numbers.htm

Coverage Policy

Local Medical Review Polices	http://www.hcfa.gov/lmrp.net/
Medicare National Coverage Policy	http://www.hcfa.gov/coverage/

Glossary - Medicare Program

This glossary explains terms in the Medicare program, but it is not a legal document. The official Medicare program provisions are found in the relevant laws, regulations, and rulings.

*__NOTE:__ An asterisk (*) after a term means that this definition, in whole or in part, is used with permission from Walter Feldesman, ESQ., Dictionary of Eldercare Terminology, Copyright 2000.

Abuse (Personal)	When another person does something on purpose that causes you mental or physical harm or pain.
Access	Your ability to get needed medical care and services.
Accessibility of Services	Your ability to get medical care and services when you need them.
Accredited (Accreditation)	A seal of approval from a private, independent group. Being accredited means that a facility has met certain quality standards.
Act / Law / Statute	Term for legislation that passed through Congress and was signed by the President or passed over his veto.
Activities of Daily Living (ADL)*	Activities you usually do during a normal day. Although definitions differ, ADLs are usually viewed as everyday activities, such as walking, getting in and out of bed, dressing, bathing, eating, and using the bathroom.
Actual Charge	The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See Approved Amount; Assignment.)
Adjusted Average Per Capita Cost (AAPCC)	An estimate of how much Medicare will spend in a year for an average beneficiary. (See Risk Adjustment.)
Adjusted Community Rating (ACR)	How premium rates are decided based on members' use of benefits and not your individual use of benefits.
Administrative Law Judge (ALJ)	A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.
Admitting Physician	The doctor responsible for admitting you to a hospital or other inpatient health facility.
Advance Beneficiary Notice (ABN)	A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases: 1. Your doctor gives you a service that he or she believes that Medicare does not consider medically necessary; and 2. Your doctor gives you a service that he or she believes that Medicare will not pay for. If you do not get an ABN to sign before you get the service from your doctor, and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor for it. ABN only applies if you are in the Original Medicare Plan. It does not apply if you are in a Medicare managed care plan. (See Medicare Managed Care Plan; Original Medicare Plan.)

Advance Coverage Decision	A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.
Advance Directives	Written ahead of time, this is your statement, of how you want to get health care. This is done in case you can't say how. Such health care could include routine treatments and life-saving methods. You can also choose someone to make medical decisions in case you can't. Advance Directives are also called a Living Will.
Advocate	A person who gives you support or protects your rights.
Affiliated Provider	A health care provider or facility that is paid by a health plan to give services to plan members.
Ambulatory Care	All types of health services that do not require an overnight hospital stay.
Ambulatory Surgical Center	A separate part of a hospital that does outpatient surgery.
Ancillary Services	Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.
Anesthesia	Drugs that a person is given before and during surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.
Annual Election Period	The Annual Election Period for Medicare beneficiaries is the month of November each year. Enrollment will begin the following January. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members. (See Election Periods.)
Appeal	An appeal is a special kind of complaint you make if you disagree with any decision about your health care services, for example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint. (See Appeals Process.)
Appeals Process	The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)

Approved Amount	The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge." (See Actual Charge, Assignment.)
Approved Amount (Home Health)	The fee Medicare sets as reasonable for a covered medical service. It may be less than the actual amount charged. Approved amount is sometimes called "approved charge." (See Actual Charge; Assignment.)
Area Agency On Aging (AAA)	State and local aging programs that help older people plan and care for their life-long needs. These needs include adult day health care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.
Assessment	The gathering of information to rate or evaluate your health and needs, such as in a nursing home.
Assignment	In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor visit. (See Actual Charge; Approved Amount; Coinsurance.)
Assisted Living Facility (ALF)	A homelike place with staff who give help to residents, including: help with dressing, bathing, feeding, and housekeeping. Assisted Living Facilities usually give a less skilled level of care than you would get in skilled nursing facilities. Medicare does not cover care in an ALF.
Balance Billing	A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.
Basic Benefits (Medigap)	Benefits provided in Medigap Plan A. They are also included in all other Medigap plans. (See Medigap.)
Beneficiary	The name for a person who has health insurance through the Medicare or Medicaid program.
Benefit Period	The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. (See Deductible; Skilled Nursing Facility.)

Benefits	The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.
Board-Certified	This means a doctor has special training in a certain area of medicine and has passed an ADVANCED exam in that area of medicine. Both primary care doctors and specialists may be board-certified.
CAHPS (Consumer Assessment of Health Plans Study)	A yearly nationwide survey that is used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.
Capitation	A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.
Care Plan	A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well being.
Carrier	A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Part B.)
Case Management	A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.
Case Manager	A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.
Catastrophic Illness	A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.
Catastrophic Limit	The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.
Centers for Medicare and Medicaid Services (CMS)	The federal agency that oversees the Medicare, Medicaid, and state Children's Health Insurance Program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
Certified (Certification)	This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.
Certified Registered Nurse Anesthetist	A nurse who is trained and licensed to give anesthesia. Anesthesia is given before and during surgery so that a person does not feel pain. (See Anesthesia.)

CHAMPUS	The Civilian Health and Medical Program was run by the Department of Defense in the past. CHAMPUS gave medical care to active duty members of the military, military retirees, and their eligible dependents. (This program is now called TRICARE.)
Claim	A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Part A; Part B.)
Clinical Practice Guidelines	Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
Cognitive Impairment	A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.
Coinsurance	The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).
Coinsurance (Assignment)	The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20% for Part B Services.) (See Assignment; Deductible (Medicare); Original Medicare Plan; Part A; Part B.)
Coinsurance (Private Fee-for Service Plan)	The percentage of the Private Fee-for-Service plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service plan, the coinsurance payment is a percentage of the cost of the service (like 20%).
Community Mental Health Center	A place where Medicare patients can go to receive partial hospitalization services.
Complaint	(See Grievance.)
Comprehensive Outpatient Rehabilitation Facility (CORF)	A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.
Conditional Payment	A payment made by Medicare in certain circumstances if the insurance company or other payer does not pay the bill within 120 days.

Confidentiality	Your right to talk with your health care provider without anyone else finding out what you have said.
Consolidated Omnibus Budget Reconciliation Act (COBRA)*	COBRA is a law that makes an employer let you remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, or having your work hours reduced, or getting a divorce. You may have to pay both your share and the employer's share of the premium.
Coordination of Benefits Clause	A written statement that tells which health plan or insurance policy pays first if two health plans or insurance policies cover the same benefits. If one of the plans is Medicare, federal law may decide who pays first.
Copayment	In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5.00 or $10.00 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.
Cost Sharing	The cost for medical care that you pay yourself, like a copayment, coinsurance, or deductible. (See Coinsurance; Copayment; Deductible.)
Covered Benefit	A health service or item that is included in your health plan, and that is paid for either partially or fully.
Covered Charges	Services or benefits for which a health plan makes either partial or full payment.
Creditable Coverage	Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions.)
Critical Access Hospital	A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.
Custodial Care	Personal care, such as bathing, cooking, and shopping. This is usually not covered by Medicare.
Deductible (Medicare)	The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Part A; Part B.)
Deductible (Part B)	The amount you must pay for health care each calendar year before Medicare begins to pay. This amount can change every year.
Deductible (Private Fee-for-Service Plan)	The amount you must pay for health care before the Private Fee-for-Service Plan begins to pay. This amount can change every year.
Deductibles (Medigap)	The amount you must pay for health care, before Medicare or some Medigap policies begin to pay. Some Medicare deductibles can change every year. (See Medigap.)

Deficiency (Nursing Home)	A finding that a nursing home failed to meet one or more federal or state requirements.
Dehydration	A serious condition where your body's loss of fluid is more than your body's intake of fluid.
Diagnosis	The name for the health problem that you have.
Diagnosis Related Groups	A way to pay hospitals for health care based on diagnosis, age, sex, and complications.
Discharge Planning	A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.
Disenroll	Ending your health care coverage with a health plan.
Dual Eligibles	Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.
Durable Medical Equipment (DME)	Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and you pay 20% coinsurance in the Original Medicare Plan.
Elder Law*	The group of laws about rights and issues of the health, finances, and well-being of the elderly.
Eldercare	Public, private, formal, and informal programs and support systems, government laws, and funding ways to meet the needs of the elderly, including: housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.
Election	Your decision to join or leave the Original Medicare Plan or a Medicare+Choice plan.
Election Periods	Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare+Choice Plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period. • Annual Election Period: The Annual Election Period is the month of November each year. Medicare health plans enroll eligible beneficiaries into available health plans during the month of November each year. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members. • Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and

	enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Health Care Financing Administration. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). • Special Election Period: You are given a Special Election Period to change Medicare+Choice plans or to return to Original Medicare in certain situations, which include: you make a permanent move outside the service area, the Medicare+Choice organization breaks its contract with you or does not renew its contract with HCFA; or other exceptional conditions determined by HCFA. The Special Election Period is different from the Special Enrollment Period (SEP). • Open Enrollment Period: If the Medicare health plan is open and accepting new members, you may join or enroll in it. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.
Eligibility / Medicare Part A	You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if: • You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or • You are under 65 and you have received Social Security disability benefits for 24 months, or • You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or • You or your spouse had Medicare-covered government employment, or • You are under 65 and have End-Stage Renal Disease. If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if: • You are age 65 or older, and • You are enrolled in Part B, and • You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.
Eligibility / Medicare Part B	You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived

	in the United States continuously during the five years immediately before the month during which you enroll in Part B.
Emergency Care	Care given for a medical emergency when you believe that your health is in serious danger -- when every second counts.
Employer Group Health Plan (GHP)	A GHP is a health plan that: 1. gives health coverage to employees, former employees, and their families, and 2. is from an employer or employee organization.
End-Stage Renal Disease (ESRD)*	Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Social Security payments if found to be disabled.
Enroll	To join a health plan.
Enrollment / Medicare Part B	You must choose whether or not you want to keep Part B. There are three periods during which you can enroll in Part B: Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP). • Initial Enrollment Period: The IEP is the first chance a person has to enroll in Part B. Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months. • General Enrollment Period: January 1 through March 31 of each year. Your Part B coverage is effective July 1 after the GEP in which you enroll. • Special Enrollment Period: You can use the SEP only if you haven't taken Part B during the IEP, because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up at any time you are covered under the Group Health Plan based on current employment. If the employment or group health coverage ends, you have 8 months to sign up. The 8 months start the month after the employment ends or the group health coverage ends, whichever comes first. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. (See Eligibility.)
Enrollment / Premium Part A	There are four periods during which you can enroll in premium Part A: Initial Enrollment Period (IEP), General Enrollment Period (GEP), Special Enrollment Period (SEP), and Transfer Enrollment Period (TEP): • Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months. • General Enrollment Period: The GEP is January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll.

	• Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because they or their spouse currently work and have group health plan coverage through the employer or union. You can sign up for premium Part A at any time you are covered under the Group Health Plan based on current employment. If the employment or group health plan coverage ends, you have 8 months to sign up. The 8 months start the month after the employment ends or the Group Health Plan coverage ends. • Transfer Enrollment Period: The TEP is for people age 65 or older who have Part B only and are enrolled in a Medicare managed care plan. You can sign up for premium Part A during any month in which you are enrolled in a Medicare managed care plan. If you leave the plan or if the plan coverage ends, you have 8 months to sign up. The 8 months start the month after the month you leave the plan or the plan coverage ends. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1. (See Enrollment.)
Episode of Care	The health care services given during a certain period of time, usually during a hospital stay.
EverCare	A CMS demonstration project developed to manage the medical care of Medicare beneficiaries who are long stay residents of a nursing home. A network of physicians and nurse practitioners, who have been trained in treating the elderly, provide this care. EverCare demonstration sites are located in Atlanta, Baltimore, Boston, Denver, Phoenix, and Tampa. The project is scheduled to end on December 31, 2001.
Evidence	Signs that something is true or not true. Doctors can use published studies as evidence that a treatment works or does not work.
Excess Charge (Medigap)*	The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. (See Actual Charge; Approved Amount; Medigap.)
Excess Charges*	The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. (See Actual Charge; Approved Amount; Medigap.)
Exclusion Period	A period of time of up to 6 months when an insurance company can delay coverage of a pre-existing condition. Sometimes called a pre-existing condition waiting period. (See Pre-Existing Condition.)
Exclusions (Medicare)	Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.
Exclusions (Medigap)	Items or services that Medigap generally does not cover, such as custodial care.

Expedited Appeal	A Medicare+Choice organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.
Expedited Organization Determination	A fast decision from the Medicare+Choice organization about whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.
Explanation of Medicare Benefits (EOMB)	A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly. (See Medicare Summary Notice; Medicare Benefits Notice.)
Federally Qualified Health Center (FQHC)	Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, Tribal health clinics, migrant health services, and health centers for the homeless.
Fee Schedule	A complete listing of fees used by health plans to pay doctors or other providers.
Fiscal Intermediary	A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")
Fiscal Year	For Medicare, a year long period that runs from October 1st through September 30th of the next year. The government and some insurance companies follow a budget that is planned for a fiscal year.
Formulary	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.
Fraud and Abuse	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service provided. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.
Free Look (Medigap)*	A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.
Freedom of Information Act (FOIA)	A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government, not to those of the Congress or Federal Courts, and does not apply to state governments, local governments, or private groups.

Gag Rule Laws	Special laws that make sure that health plans let doctors tell their patients complete health care information. This includes information about treatments not covered by the health plan. These laws make it illegal to include "gag" clauses in doctor contracts, which limit a doctor's ability to give information to patients about treatment choices for a health problem.
Gaps	The costs or services that are not covered under the Original Medicare Plan. Also called Medicare gaps.
Gatekeeper	In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.
General Enrollment Period (GEP)	The GEP is January 1 through March 31 of each year. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1. (See Enrollment.)
Gerontology*	The study of, and learning about, older people and the process of aging.
Grievance	A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior, or operating hours. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.
Group Health Plan	A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.
Group or Network HMO	A health plan that contracts with group practices of doctors to give services in one or more places.
Guarantee Issue Rights	A right you have in certain situations when insurance companies are required by law to issue you a Medigap policy.
Guaranteed Renewable	A Medigap policy that your insurance company must allow you to automatically renew or continue, unless you do not pay your premiums.
Guaranteed Renewable (Medigap)	A right that you have that requires your Medigap insurance company to allow you to renew or continue your policy unless you do not pay your premiums.
Health Care Provider	A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
Health Employer Data and Information Set (HEDIS)	A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare and Medicaid Services (CMS) collects HEDIS data for Medicare plans. (See Centers for Medicare and Medicaid Services.)
Health Insurance Portability and	A law passed in 1996, which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another. HIPAA protects you

Accountability Act (HIPAA)	and your family if you have: • pre-existing medical conditions, and/or • problems getting health coverage, and you think it is based on past or present health. HIPAA also: • limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; • usually gives you credit for health coverage you have had in the past; • may give you special help with group health coverage when you lose coverage or have a new dependent; and • generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.
Health Maintenance Organization (HMO)	A group of doctors, hospitals, and other health care providers who agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.
HMO with a Point of Service (POS) Option	A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan.)
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.
Home Health Care	Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury. (See Activities of Daily Living.)
Homebound	Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for nonmedical reasons, such as a trip to the barber or to attend religious services. A need for adult day care does not keep you from getting home health care for other medical conditions.
Hospice	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).

Hospital Insurance (Part A)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
Hospitalist	A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.
Hydration	This is the level of fluid in the body. The loss of fluid, or dehydration, occurs when you lose more water or fluid than you take in. Your body cannot keep adequate blood pressure, get enough oxygen and nutrients to the cells, or get rid of wastes if it has too little fluid.
Information, Counseling, and Assistance Program	(See State Health Insurance Assistance Program.)
Initial Coverage Election Period	The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in number of members. This limit is approved by the Centers for Medicare and Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods, Enrollment; Initial Enrollment Period.)
Initial Enrollment Period (IEP)	The IEP is the first chance a person has to enroll in Part B or Part A (if you don't get it automatically without paying a premium). Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months. The Initial Enrollment Period is different from the Initial Coverage Election Period. (See Enrollment; Election Periods; Initial Coverage Election Period.)
Initial Enrollment Questionnaire (IEQ)	A questionnaire sent to you to find out if you have other insurance that should pay your medical bills before Medicare (See Medicare Secondary Payer).
Inpatient Care	Health care that you get when you stay overnight in a hospital.
Insolvency	When a health plan has no money or other means to stay open and give health care to patients.
Intermediary	A private company that contracts with Medicare to pay Medicare (Part A) bills. (Same as "Fiscal Intermediary.")
Internist	A doctor who finds and treats health problems in adults.

Large Group Health Plan	A group health plan that covers employees of either an employer or employee organization that employs 100 or more employees.
Liability Insurance	Liability insurance is insurance that protects against claims based on negligence or inappropriate action or inaction, which results in bodily injury or damage to property.
Lifetime Reserve Days (Medicare)	Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($406 in 2002).
Limiting Charge	The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. (See Approved Amount; Assignment.)
Long-Term Care Ombudsman	A supporter for nursing home patients who works to solve problems between patients and nursing homes. These are also called "Ombudsman."
Malnutrition	A health problem caused by the lack (or too much) of needed nutrients.
Mammogram	A special x-ray of the breasts. Medicare covers the cost of a mammogram once every 12 months for women over 40 who are enrolled in Medicare.
Mediate	To settle differences between two parties.
Medicaid	A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
Medicaid Only Dual Eligibles (Non-QMB, -SLMB, -QI)	Medicare beneficiaries who are entitled to Medicare Part A and/or Part B and qualify for full Medicaid benefits.
Medical Insurance (Part B)	The part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A doesn't cover, like physical and occupational therapy. (See Medicare Part B.)
Medical Underwriting	The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for preexisting conditions (if your state law allows it), and how much to charge you for that insurance.

Medically Necessary	Services or supplies that: • are proper and needed for the diagnosis, or treatment of your medical condition; • are used for the diagnosis, direct care, and treatment of your medical condition; • meet the standards of good medical practice in the local community; and • are not mainly for the convenience of you or your doctor. •
Medicare	The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
Medicare + Choice	A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.
Medicare Benefits Notice	A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) (for Part B services) or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)
Medicare Carrier	A private company that contracts with Medicare to pay Part B bills.
Medicare Coverage	Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare Part A and Medicare Part B.)
Medicare Managed Care Plan	These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.
Medicare Medical Savings Account Plan (MSA)	A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.
Medicare Part A (Hospital Insurance)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
Medicare Part B	Medical insurance that helps pay for doctors' services, outpatient hospital

(Medical Insurance)	care, and other medical services that are not covered by Part A. (See Medical Insurance.)
Medicare Premium Collection Center (MPCC)	The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.
Medicare Secondary Payer	Any situation when another insurance policy, plan, or program pays your medical bills before Medicare.
Medicare SELECT	A type of Medigap policy that may require you to use hospitals and in some cases doctors, within its network to be eligible for full benefits.
Medicare Summary Notice (MSN)	A notice you get after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services. (See Explanation of Medicare Benefits; Medicare Benefits Notice.)
Medicare Supplement Health Insurance Policy	A Medicare supplement health insurance policy is called a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps; Supplemental Insurance.)
Medigap	A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps; Supplemental Insurance.)
Medigap Protections	Your rights to buy a Medigap policy in certain situations after your Medigap open enrollment period ends.
Multi-employer Group Health Plan	A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.
National Committee for Quality Assurance (NCQA)	A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system. (See Health Employer Data and Information Set.)
National Median Charge	The national median charge is the exact middle amount of the amounts charged for the same service. This means that half of the hospitals and community mental health centers charged more than this amount and the other half charged less than this amount for the same service.

Neglect	When care takers do not give a person they care for the goods or services needed to avoid harm or illness.
Network	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
No-Fault Insurance	No-fault insurance is insurance that pays for health care services resulting from bodily injury or damage to your property regardless of who is at fault for causing the accident.
Nonparticipating Physician	A doctor or supplier who does not accept assignment on all Medicare claims. (See Assignment.)
Notice of Medicare Benefits	A notice that you get to show what action was taken on a claim. (See Explanation of Medicare Benefits; Medicare Benefits Notice; Medicare Summary Notice.)
Notice of Medicare Premium Payment Due - HCFA 500	The billing notice sent to Medicare beneficiaries who must pay their Medicare premium directly. Notices are sent either monthly or quarterly.
Nurse Practitioner (NP)	A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the things a doctor does.
Nursing Home	A place that gives nursing care, help with healing after an injury or hospital stay, or custodial care. Medicare does not pay for nursing home care, but Medicaid may.
Occupational Therapy	Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after an illness either on an in- or out-patient basis.
Ombudsman	A supporter for nursing home patients who works to solve problems between patients and nursing homes. Also called "Long-Term Care Ombudsman."
Open Enrollment Period (Medigap)	A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your history during this time.
Open Enrollment Periods	A certain period of time when you can join a Medicare health plan. The plan must be open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join. (See Election Periods.)
Organization Determination	A health plan's decision on whether to pay all or part of a bill, or to give medical services, after you file an appeal. If the decision is not in your favor, the plan must give you a written notice. This notice must give a reason for the denial and a description of steps in the appeals process. (See also Appeals Process.)

Original Medicare Plan	A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). (See Deductible (Medicare); Approved Amount; Coinsurance; Part A; Part B.)
Out-of-Pocket Costs	Health care costs that you must pay on your own, because they are not covered by Medicare or other insurance.
Outpatient Care	Medical or surgical care that does not include an overnight hospital stay.
Outpatient Hospital Services* (Medicare)	Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including: • blood transfusions; • certain drugs; • hospital billed laboratory tests; • mental health care; • medical supplies such as splints and casts; • emergency room or outpatient clinic, including same day surgery; and • x-rays and other radiation services.
Outpatient Prospective Payment System	The way that Medicare will pay for most outpatient services at hospitals or community mental health centers under Medicare Part B.
Part A (Medicare)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
Part B (Medicare)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. (See Medical Insurance.)
Partial Hospitalization	A structured program of active treatment for psychiatric care that is more intense than the care you get in your doctor's or therapist's office.
Participating Physician or Supplier	A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors/suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)
Patient Advocate	A hospital employee whose job is to speak on a patient's behalf and help patients get any information or services they need.
Payment Rate	The total payment that a hospital or community mental health center gets when they give outpatient services to Medicare patients.
Peer Review Organization (PRO)	Groups of practicing doctors and other health care experts. They are paid by the federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of

	care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.
Periods of Care (Hospice)	A set period of time that you can get hospice care after your doctor says that you are eligible and still need hospice care.
Physical Therapy	Treatment of injury and disease by mechanical means, as heat, light, exercise, and massage.
Physician Assistant (PA)	A person who has 2 or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.
Plan of Care	Your doctor's written plan saying what kind of services and care you need for your health problem.
Pre-Existing Condition (Medigap)	A health problem for which you got medical treatment or advice within 6 months of the date that a new insurance policy starts.
Preferred Provider Organization (PPO)	A managed care plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Premium	The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.
Preventive Care	Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.
Primary Care	A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetrician), and children (pediatrician). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.
Primary Care Doctor	A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.
Primary Payer	An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.
Private Contract	A contract between you and a doctor who has decided not to offer services through the Medicare program. This doctor cannot bill Medicare for any service or supplies given to you and other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.

Private Fee-for-Service Plan	A private insurance plan that accepts medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan does not cover
Procedure	Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.
Program of All-Inclusive Care For the Elderly	PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.
Pros and Cons	The good and bad parts of treatment for a health problem. For example, a medicine may help your pain (pro), but it may cause an upset stomach (con).
Protections and Guarantees (Medigap)	Your rights to buy a Medigap policy in certain situations after your Medigap open enrollment period.
Provider	A doctor, hospital, health care professional, or health care facility.
Provider Sponsored Organization (PSO)	A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)
Qualified Medicare Beneficiary (QMB)	This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A, a low monthly income, and limited money or assets to pay for health care services. In this program, the Medicaid program pays the Medicare Part A premiums, Part B premiums, Medicare deductibles and coinsurance amounts for Medicare services.
Qualifying Individuals (1) (QI-1s)	This is a Medicaid program for certain individuals who need help in paying for Medicare services. The individual must have Medicare Part A, a low monthly income, and limited money or assets to pay for Medicare services. The Medicaid program pays full Medicare Part B premiums only. This program is for certain individuals who do not meet Medicaid eligibility requirements.
Qualifying Individuals (2) (QI-2s)	This is a Medicaid program for certain individuals who need help in paying for Medicare services. The individual must have Medicare Part A, a low income, and limited money or assets to pay for Medicare services. In this program, Medicaid pays a percentage of Medicare Part B

	premiums only. This program is for individuals who do not meet Medicaid eligibility requirements.
Quality	Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.
Quality Assurance	The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.
Referral	An OK from your Primary Care Doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care. (See Emergency Care, Primary Care Doctor, Urgently Needed Care.)
Regional Home Health Intermediaries	A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.
Reserve Days	(See Lifetime reserve days.)
Respite Care	Care given to a hospice patient by another caregiver so that the usual caregiver can rest.
Restraint	Any physical or chemical way to stop a patient from being free to move. These restraints are used to prevent patient injury and are not used for treating medical symptoms.
Risk Adjustment	The way that payments to health plans are changed to take into account a person's health status.
Savings for Medicare Beneficiaries	Medicaid programs that help pay Medicare out-of-pocket expenses.
Second Opinion	This is when another doctor gives his or her view about what you have and how it should be treated.
Secondary Payer	An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.
Service Area	The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.
Service Area (Private Fee-for-Service)	The area where a Private Fee-for-Service plan accepts members.

Side Effect	A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.
Skilled Nursing Care*	A level of care that must be given or supervised by licensed nurses. This care is also under the general direction of a doctor. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.
Skilled Nursing Facility (SNF)	A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.
Skilled Nursing Facility Care*	A level of care that must be given or supervised by licensed nurses or other professional staff, such as physical and occupational therapists under the general direction of a doctor. All of your needs are taken care of with this type of service, including getting direct services. Examples of skilled care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound, physical occupational, and speech-language therapy. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered
Social Health Maintenance Organization (SHMO)	A special type of health plan that provides the full range of Medicare benefits offered by standard Medicare HMOs, plus other services that include the following: • prescription drug and chronic care benefits, respite care, and short-term nursing home care; and • homemaker, personal care services, and medical transportation. • eyeglasses, hearing aids, and dental benefits. •
Special Election Period	A set time that a beneficiary can change health plans or to return to the Original Medicare Plan, such as: you move outside the service area, your Medicare+Choice organization violates its contract with you, the organization does not renew its contract with CMS, or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period.)
Special Enrollment Period (SEP)	A set time when you can sign up for Medicare Part B if you did not take Part B during the Initial Enrollment Period, because you or your spouse currently work and have group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have 8 months to sign up. The 8-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes

	first. The Special Enrollment Period is different from the Special Election Period. (See Enrollment; Election Periods; Special Election Period.
Specialist	A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.
Specified Low-Income Medicare Beneficiaries (SLMB)	A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
State Buy-in	State Buy-in is the program through which the State Medicaid Agencies pay Part A and/or Part B Medicare premiums on behalf of Medicare beneficiaries who are members of one of the Medicaid coverage groups for which the State has agreed to pay Medicare premiums. Not all Medicare beneficiaries who receive Medicaid benefits are eligible for State Buy-in.
State Health Insurance Assistance Program (SHIP)	A state program that gets money from the federal Government to give free health insurance counseling and assistance to people with Medicare.
Supplier	Generally, any company, person, or agency that gives you a medical item or service; like a wheelchair or walker.
Treatment	Something done to help with a health problem. For example, medicine and surgery are treatments.
Treatment Options	The choices you have when there is more than one way to treat your health problem.
TRICARE	TRICARE is the health care program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was called the CHAMPUS program in the past. (See CHAMPUS.)
Unforeseen Out-of-Area Urgently Needed Care	Care you get for a sudden illness or injury that needs medical care right away, but is not life threatening, while you are out of your health plan's service area for a short time, and can not wait until you return home.
Urgently Needed Care	Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.
Waiting Period	The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.
Workers Compensation	Insurance that employers are required to have to cover employees who get sick or injured on the job.