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CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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The e-News for Thu Mar 15 includes...

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National Provider Call: Physician Quality Reporting System & eRx: Million Hearts Initiative – Last Chance to Register [[↑](#)]

Tue Mar 20; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program, during which subject matter experts will provide an overview of the HHS [Million Hearts Initiative](#).

Target Audience: All Medicare FFS providers, medical coders, physician office staff, provider billing staff, Electronic Health Records staff, and vendors

Agenda:

- Opening remarks
- Program announcements
- Overview of Million Hearts Initiative
- Question & answer session

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp. In addition, the presentation will be emailed to all registrants on the day of the call.

To learn more about CMS National Provider Calls, visit <http://www.CMS.gov/NPC>. This website includes a list of upcoming and past National Provider Calls and call materials (slide presentations, written transcripts, audio files, podcasts, and video slideshow presentations on the [CMS YouTube Channel](#)). Bookmark this site for newly-listed National Provider Calls and related call materials.

National Provider Call: Medicare Preventive Services: Initial Preventive Physical Exam and Annual Wellness Visit – Register Now [[↑](#)]

Wed Mar 28; 2:30-4pm ET

Don't miss this opportunity to get the information you need about the Initial Preventive Physical Exam (IPPE – also known as the “Welcome to Medicare” Preventive Visit) and the Annual Wellness Visit (AWV). This year, the CY2012 Medicare Physician Fee Schedule Final Rule added a Health Risk Assessment to the AWV. CMS experts will be on hand to discuss both the IPPE and AWV, when to perform them, who can perform each service, who is eligible, and how to code and bill for each service, followed by a question and answer session.

Target Audience: Physicians, physician assistants, nurse practitioners, clinical nurse specialists, health educators, registered dietitians, nutrition professionals, medical billers and coders, and other interested healthcare professionals

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. Registration will

close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at <http://www.CMS.gov/NPC/Calls/itemdetail.asp?itemID=CMS1256439>. In addition, the presentation will be emailed to all registrants on the day of the call.

To learn more about CMS National Provider Calls, visit <http://www.CMS.gov/NPC>. This website includes a list of upcoming and past National Provider Calls and call materials (slide presentations, written transcripts, audio files, podcasts, and video slideshow presentations on the [CMS YouTube Channel](#)). Bookmark this site for newly-listed National Provider Calls and related call materials.

National Provider Call: Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals – Save the Date [[↑](#)]

Thu Mar 29; 3-4:30pm ET

As of Tue Jan 31, more than \$3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made; more than 191,000 eligible professionals, eligible hospitals, and critical access hospitals are actively registered. Learn if you are eligible and, if so, what you need to do to earn an incentive. This session will inform individual practitioners about the basics of the Medicare & Medicaid EHR Incentive Programs. *Remember: This is the last year that eligible professionals can participate in Medicare and get the maximum incentive payment.*

Target Audience: Eligible Professionals (EPs), which include Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, Chiropractors, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants (PA) who practice at an FQHC/RHC led by a PA. (Note that hospital-based EP's may not participate; an EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.) Medicaid eligible professionals must meet patient-volume criteria, providing services to those attributable to Medicaid or, in some cases, needy individuals.)

Agenda:

- Are you eligible?
- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and Answer Session

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. Registration will open soon and will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at <http://www.CMS.gov/NPC/Calls>. In addition, the presentation will be emailed to all registrants on the day of the call.

To learn more about CMS National Provider Calls, visit <http://www.CMS.gov/NPC>. This website includes a list of upcoming and past National Provider Calls and call materials (slide presentations, written transcripts, audio files, podcasts, and video slideshow presentations on the [CMS YouTube Channel](#)). Bookmark this site

for newly-listed National Provider Calls and related call materials.

Special Open Door Forum: Medicare's Prior Authorization for Power Mobility Devices Demonstration [[↑](#)]

Wed Mar 21; 3-4:30pm ET

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers.

CMS received many comments/suggestions on the Prior Authorization of Power Mobility Devices (PMDs) demonstration and has considered these comments carefully. In response to comments received from stakeholders, CMS has made a number of modifications to the Prior Authorization of PMD demonstrations:

- CMS has completed a separate Paperwork Reduction Act (PRA) notification for this demonstration.
- CMS has removed the 100% Pre-Payment review phase (formerly Phase 1).
- CMS will allow suppliers to perform the administrative function of submitting the prior authorization request on behalf of the physician/ treating practitioner.
- This demonstration will begin only after an OMB PRA control number is obtained. CMS anticipates the *start of this demonstration will be on or after Fri June 1, 2012.*

To read more about the demonstration, visit http://www.CMS.gov/CERT/03_PADemo.asp.

Participation Instructions: Full instructions on participating in this conference call, submitting questions in advance, and accessing audio recordings and transcripts afterward, are available at <http://www.CMS.gov/OpenDoorForums/Downloads/032112SODFMedicarePriorAuthPMDDemo.pdf>.

Future Special Open Door Forums on Medicare's Prior Authorization for Power Mobility Devices Demonstration have been scheduled for Thu Apr 26, Thu May 31, Thu June 28, and Fri July 27 at 3pm; call information to be announced.

"Long Term Care Hospital Quality Reporting Program" Train-the-Trainer Conference – Register by Wed Mar 21 [[↑](#)]

Tue May 1 and Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201

To support the implementation of the Long Term Care Hospital (LTCH) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS is hosting a LTCH QRP Train-the Trainer Conference on Tue May 1 and Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all long-term care hospital providers, associations, and organizations that support quality care in the nation's long-term care hospitals. The goals of the conference are to:

- Introduce the structure of the LTCH Care Data Set, the data collection instrument that will be used by LTCHs to collect data on the measure, Percent of Patients with a Pressure Ulcer That is New or Worsened

- Discuss assessment procedures and coding for key sections
- Discuss and understand data submission specifications
- Presentations by the Centers for Disease Control and Prevention on the Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Blood Stream Infection (CLABSI) measures as well as the use of the National Health Safety Network (NHSN) for submitting data associated with these measures

Registration for the conference ends Wed Mar 21. Hotel registrations will not be accepted until registration begins, at which time reservations may be made by phone or online.

Additional information is available at the conference website at www.totalsolutions-inc.com/natconference, and questions can be submitted to conference2@totalsolutions-inc.com.

For more information on the LTCH QRP, visit the [Long Term Care Hospital Quality Reporting Program](#) website.

- Additional material related to Long Term Care Hospitals in today's e-News... [\[next\]](#)

“Inpatient Rehabilitation Facility Patient Assessment Instrument New Quality Indicators Section” Train-the-Trainer Conference – Last Chance to Register [\[↑\]](#)

Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201

To support the implementation of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS will host an “IRF Patient Assessment Instrument (PAI) New Quality Indicators” Train-the-Trainer Conference on Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all Inpatient Rehabilitation Facility providers, associations, and organizations that support quality care in inpatient rehabilitation facilities. The goals of the conference are to:

- Introduce the Quality Indicator item set that has been added to the IRF-PAI
- Discuss assessment procedures and coding for the 2 quality measures:
 - Catheter Associated Urinary Tract Infections (CAUTI), and
 - Pressure Ulcers
- Discuss data submission specifications, including presentations by the Centers for Disease Control and Prevention on the CAUTI, and the use of the National Health Safety Network for submitting data associated with this measure

Note that this training is specific to the new Quality Indicators Section of the IRF-PAI and the reporting of CAUTI data to the CDC. The training will not cover the IRF-PAI in its entirety.

Registration for the conference ends Fri Mar 16. Hotel reservations will not be accepted until registration has closed, at which time reservations may be made by phone or online; each participant will be limited to one room reservation.

Additional information is available at the conference website at www.totalsolutions-inc.com/natconference, and questions can be submitted to

Extension of Enforcement Discretion Period for Updated *HIPAA* Transaction Standards through June 30, 2012 [\[↑\]](#)

(March 15, 2012) The Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) is announcing that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions. If any entity is experiencing difficulty reaching a MAC, please contact Karen Jackson at Karen.Jackson1@cms.hhs.gov.

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

➤ Additional material related to Version 5010 in today's e-News... [\[next\]](#)

Ensure a Smooth Version 5010 Upgrade with CMS Online Resources [\[↑\]](#)

The Version 5010 upgrade deadline was Sun Jan 1, 2012; however, CMS initiated an enforcement discretion period to give everyone covered by *HIPAA* additional time to complete testing and meet compliance. You should be finalizing your upgrade to Version 5010 if you have not yet done so.

CMS is committed to helping you successfully upgrade to Version 5010 by providing resources on the CMS ICD-10 website to understand and manage your upgrade. Take a look at the [Version 5010 section](#) of the CMS ICD-10 website to find out more about the upgrade and available resources.

CMS has also created several helpful factsheets on Version 5010, including:

- [Version 5010, D.O, and 3.0 Basics](#) – providing an overview of Version 5010, D.O, and 3.0
- [FAQS: Versions 5010 and D.O Basics](#) – lists many frequently-asked-questions about the Version 5010 upgrade
- [Version 5010 Testing Readiness](#) – explaining the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing
- [Version 5010: Ensuring a Smooth Transition](#) – provides steps to assist your upgrade to Version 5010

Keep Up to Date on Version 5010 and ICD-10. Visit [the ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today!

- Additional material related to Version 5010 in today's e-News... [\[previous\]](#)

CMS Continues Effort to Improve Quality of Care for People with Medicare – New Partners Named in Community-Based Care Transitions Program [\[↑\]](#)

As part of the new healthcare law's policies to improve the quality of care available to people with Medicare and all Americans, on Wed Mar 14 CMS announced 23 additional participants in the *Community-based Care Transitions Program* (CCTP). These participants will join seven other community-based organizations already working with local hospitals and other healthcare and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care setting.

CCTP is designed specifically to provide support for high-risk Medicare beneficiaries following a hospital discharge. These 23 sites will work with CMS and local hospitals to provide support for patients as they move from hospitals to new settings, including skilled nursing facilities and home. Community organizations will help these patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. This announcement will support more than 126 local hospitals and help more than 223,000 Medicare beneficiaries in 19 states across the country.

CCTP is part of the [Partnership for Patients](#), a public-private partnership aiming to cut preventable errors in hospitals by 40 percent and reduce preventable hospital readmissions by 20 percent over a three-year period. Achieving these goals has the potential to save up to 60,000 lives, prevent millions of injuries and unnecessary complications in patient care, and save up to \$50 billion for Medicare over ten years. To date, more than 8,000 partners have pledged their commitment to the aims of the *Partnership for Patients*, including more than 3800 hospitals.

As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high-risk for readmission to the hospital. The 23 sites will join the seven organizations announced in November 2011, bringing the total number of sites to 30. This is the second round of CCTP participants announced since the program was launched in April 2011.

More information on the CCTP is available at <http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313>. More information about the

work the Department of Health and Human Services is doing to improve care for Medicare, Medicaid, and CHIP beneficiaries and, by extension, all Americans through the broader *Partnership for Patients* initiative is available at <http://www.HealthCare.gov/PartnershipForPatients>.

The full text of this excerpted CMS press release (issued Wed Mar 14) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4302>.

➤ Additional material related to Hospital Readmissions in today's e-News... [\[next\]](#)

CMS.gov Website Upgrade [\[↑\]](#)

CMS is in the process of making upgrades to the www.CMS.gov website. If you encounter problems accessing information while on the site, please refresh the page or check back later. We appreciate your understanding and apologize for any inconvenience.

Social Security Applicants to Sign Authorization Electronically [\[↑\]](#)

We are forwarding this message on behalf of the Social Security Administration. Providers with questions regarding this message may contact the local [Professional Relations Officer](#) at the State Disability Determination Services.

Beginning April 2012, adults filing online for Social Security disability benefits on their own behalf will be able to electronically sign and submit their medical release form, "Authorization to Disclose Information to the Social Security Administration" (Form [SSA-827](#)). Healthcare providers will continue to receive a *Health Insurance Portability and Accountability Act (HIPAA)* compliant SSA-827 with each of Social Security's requests for records. The only change to the current form will be in the completed signature block, which will indicate that the applicant electronically signed using the new process. Accepting electronic signatures on SSA-827s will help speed the disability benefits application process. For more information about this process, visit <http://go.usa.gov/P7V>.

New Opportunity for Better Care for Nursing Facility Residents through Enhanced Coordination Efforts – New Initiative to Improve Care for Medicare-Medicaid Enrollees and Reduce Costly and Avoidable Hospitalizations [\[↑\]](#)

On Thu Mar 15, CMS announced the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*, a new effort designed to improve care for people living in nursing facilities who are enrolled in Medicare and Medicaid. The initiative aims to reduce costly and avoidable hospitalizations among nursing facility residents by funding organizations that would partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents. CMS commits up to \$128 million to support a diverse portfolio of these evidence-based interventions.

The initiative will be run collaboratively by the CMS Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation, both created by the *Affordable Care Act* to improve the quality and costs of care in the Medicare and Medicaid programs. Through this initiative, CMS will partner with independent organizations to improve care for long-stay nursing facility residents. These organizations will collaborate with nursing facilities and states to provide coordinated, person-centered care with the goal of reducing avoidable hospital stays. Eligible organizations can include physician practices, care management organizations, and other public and not-for-profit entities.

CMS issued a Request for Applications on Thu Mar 15; organizations interested in participating in this initiative must submit an application by Thu June 14, 2012.

More information about this initiative, including the Request for Applications, is available at <http://Innovation.CMS.gov/initiatives/rahnfr>, or by searching for CFDA 93.621 at www.Grants.gov.

The full text of this excerpted CMS press release (issued Thu Mar 15) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4303>. A media factsheet can be found at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4304>.

➤ Additional material related to Hospital Readmissions in today's e-News... [\[previous\]](#)

All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer [\[↑\]](#)

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.*

For more information about provider enrollment revalidation, review the Medicare Learning Network's [Special Edition Article #SE1126](#), titled "Further Details on the Revalidation of Provider Enrollment Information."

Technical Specifications Update for the Long Term Care Hospital Quality Reporting Program [\[↑\]](#)

CMS is pleased to announce that the draft Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set Technical Specifications Draft Version 1.00.1 has been posted to the [LTCH Quality Reporting Technical Information](#) webpage on the CMS website.

The [Draft LTCH CARE Data Set Version 1.00.1 Specifications for October 2012](#) zip file includes a specification change document identifying changes since draft version 1.00.0. Final specifications will be posted in the near future. The zip file also contains the updated "Draft" LTCH CARE Data submission specifications.

The files posted on the website within the zip file include:

- LTCH Data Submission Spec Changes (v1.00.1)
- LTCH 1.0 data specs overview (v1.00.1) Draft
- LTCH data dictionary (v1.00.1) Draft
- LTCH data specs CSV files (v1.00.1) Draft
- LTCH data specs HTML files (v1.00.1) Draft
- LTCH data specs PDF files (v1.00.1) Draft

➤ Additional material related to Long Term Care Hospitals in today's e-News... [\[previous\]](#)

From the MLN: “Global Surgery” Fact Sheet Released [[↑](#)]

The MLN “[Global Surgery](#)” fact sheet (ICN 907166) has been released and is now available in downloadable format. This fact sheet is designed to provide education on the components of a global surgery package, and includes information about billing and payment rules for surgeries, endoscopies, and global surgical packages that are split between two or more physicians.

From the MLN: “Telehealth Services” Fact Sheet Revised [[↑](#)]

The “[Telehealth Services](#)” fact sheet (ICN 901705) has been revised and is now available in downloadable format. It includes the information about services furnished to eligible Medicare beneficiaries via a telecommunications system, including originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, and billing and payment for the originating site facility fee.

From the MLN: “Contractor Entities At A Glance” Educational Tool Available in Downloadable and Hardcopy Formats [[↑](#)]

Please note that the “[Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities](#)” educational tool (ICN 906983) is available in both downloadable and hardcopy formats. This tool is designed to provide education on the definitions and responsibilities of entities who are involved claims adjudication activities; it includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially Fee-For-Service providers. To order hardcopies of this product, visit <http://www.CMS.gov/MLNProducts> and click on ‘MLN Product Ordering Page’ under ‘Related Links Inside CMS’ at the bottom of the webpage.

More Helpful Links...

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive