REFERENCE INFORMATION

REFERENCE SECTION

REFERENCE A
GLOSSARY

A

Advance Beneficiary Notice
A written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare.

Aged Insured
A beneficiary who is eligible for premium-free Part A on the basis of age is age 65 years or older and either eligible for monthly Social Security or Railroad Retirement cash benefits or would be eligible for such benefits if the worker's quarters of coverage (QC) from government employment were regular Social Security QCs.

Aged Uninsured
An aged individual who is age 65 years or older, is eligible for Part A, and is not insured but elects to purchase Part A coverage by filing an application at a Social Security office. Because a monthly premium is required, this coverage is called premium Part A.

Appeal
An independent review of an initial determination made by a Medicare Contractor.

Assignment
When a provider or supplier is paid the Medicare allowed amount as payment in full for his or her services.

B

Balanced Budget Act of 1997
Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits. Also established the State Children's Health Insurance Program and Medicare Advantage.

Beneficiary
Individual eligible to receive Medicare or Medicaid payment and/or services.

Benefits Improvement and Protection Act of 2000
Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and State Child Health Insurance Program.

C

Carrier
Centers for Medicare & Medicaid Services Contactor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
Federal agency that administers and oversees the Medicare Program and a portion of the Medicaid Program.

Centers for Medicare & Medicaid Services Certification Number (formerly Online Survey Certification and Reporting Number)
Assigned by the Centers for Medicare & Medicaid Services Regional Offices to institutional providers and certain certified suppliers who meet the Conditions of Participation or Coverage in the Medicare Program (note that these numbers are being replaced by National Provider Identifiers in claims processing and other Health Insurance Portability and Accountability Act standard transactions such as eligibility and claim status inquiries).

Certificate of Medical Necessity
Form that is included with claims for certain items that require additional information.

Claim
Request for payment of Medicare benefits or services furnished by a provider or received by a beneficiary.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Under Original Medicare or a Private Fee-for-Service Plan, a percentage of covered charges that the Medicare beneficiary may have to pay after he or she has met the applicable deductible.

Comprehensive Error Rate Testing
Program that measures and improves the quality and accuracy of Medicare claims submission, processing, and payment.

Consultation
Primarily performed at the request of a referring physician or practitioner in order to provide him or her with advice or an opinion.

Coordination of Benefits
The process that determines the respective responsibilities of two or more payers that have some financial responsibility for a medical claim.

Copayment
In some Medicare health plans, the amount that is paid by the beneficiary for each medical service.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
Reasonable and necessary service furnished to Medicare or Medicaid patients and reimbursable to the provider, supplier, or beneficiary.

Critical Access Hospital
Hospital that is located in a State that has established a State Medicare Rural Hospital Flexibility Program; is located in a rural area or treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a Critical Access Hospital (CAH); furnishes 24-hour emergency care services, using either on-site or on-call staff; provides no more than 25 inpatient beds; has an average annual length of stay of 96 hours or less; and is located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR is State certified by December 31, 2005 as a “necessary provider” of health care services to residents in the area.

D

Deductible
Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Deficit Reduction Act of 2005
Legislation enacted on February 8, 2006 that saves funds by slowing the growth in spending for Medicare and Medicaid and other measures.

Department of Health and Human Services
Federal department that administers many health and welfare programs for citizens of the U.S. and is the parent agency of the Centers for Medicare & Medicaid Services.

Disabled Insured
An insured beneficiary who is entitled to Social Security or Railroad Retirement benefits on the basis of disability is automatically entitled to Part A after 24 months of entitlement to such benefits. In addition, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if their quarters of coverage (QC) from government employment were Social Security QCs are deemed to be entitled to disability benefits and automatically entitled to Part A after being disabled for 29 months.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

Durable Medical Equipment Medicare Administrative Contractor Information Form
Form that is included with claims for certain items that require additional information.

E

End-Stage Renal Disease Insured
Individuals who are eligible for Part A if they receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions: have worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee; are receiving or are eligible for Social Security or Railroad Retirement benefits; are the spouse or dependent child of an individual who has worked the required amount of time

under Social Security, the RRB, or as a government employee; or are receiving Social Security or Railroad Retirement benefits.

F

Federally Qualified Health Center
Entity that is receiving a grant under Section 330 of the Public Health Service Act (PHS), receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act, not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (i.e., qualifies as a Federally Qualified Health Center look-alike) based on the recommendation of the Health Resources and Services Administration, or operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fiscal Intermediary
Centers for Medicare & Medicaid Services Contractor that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

H

Healthcare Common Procedure Coding System
The uniform method for providers and suppliers to report professional services, procedures, and supplies. It includes Current Procedural Terminology codes and national alphanumeric codes.

Health Care Fraud
Generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal Health care program.

Health Professional Shortage Area
Geographic areas that have been designated as primary medical care shortage areas where physicians who furnish medical care are entitled to a Medicare incentive payment.

Home Health
The following criteria must be met in order for the Medicare Program to reimburse a Home Health Agency (HHA) for home health (HH) services: the

patient is an eligible Medicare beneficiary, the HHA that furnishes services to the patient has a valid agreement to participate in the Medicare Program and meets all of the HH Conditions of Participation, the patient qualifies for coverage of HH services, the services for which payment is claimed are covered and not otherwise excluded from payment, and Medicare is the appropriate payer.

Hospice
An elected benefit covered under Part A for a beneficiary who meets all the following conditions: The individual is eligible for Part A; the individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course; the individual receives care from a Medicare-approved hospice program; and the individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

I

Incentive Payment
Payments paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care Health Professional Shortage Areas or Physician Scarcity Areas.

Incentive Reward Program
Encourages the reporting of information regarding individuals or entities that commit fraud or abuse that could result in sanctions under any Federal health care program.

Incident To Provision
Services that are commonly furnished in physicians' offices or clinics; furnished by the physician or auxiliary personnel under the direct personal supervision of a physician; commonly furnished without charge or included in the physician's bill; and are an integral, although incidental, part of the physician's professional service.

L

Local Coverage Determination
Developed by local Medicare Contractors to further define or in the absence of a specific National Coverage Determination. Made at the Contractor's own discretion to provide guidance to the public and the medical community within a specified geographic area.

M

Medicaid
A cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources.

Medically Necessary
Services or supplies that are proper and needed for diagnosis or treatment of the patient's medical condition; furnished for the diagnosis, direct care, and treatment of the patient's medical condition; meet standards of good medical practice; and are not mainly for the convenience of the patient, provider, or supplier.

Medical Review
Review of claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems (e.g., errors in billing a specific type of service) are identified.

Medicare Administrative Contractor
As mandated by Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, new single authorities that Fiscal Intermediaries and Carriers will be integrated into beginning in 2006.

Medicare Advantage; Part C of the Medicare Program
A program through which organizations that contract with the Centers for Medicare & Medicaid Services provide or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Medicare Economic Index
Index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. Since 1992, the Medicare Economic Index is considered in connection with the update factor for the Medicare Physician Fee Schedule.

Medicare Physician Fee Schedule
Basis for which Medicare Part B pays for physician services. Lists the more than 7,000 covered services and their payment rates.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill that was signed by President George W. Bush on December 8, 2003 that expands many parts of the Medicare Program.

Medicare Summary Notice
Notice that beneficiaries receive on a monthly basis; lists all services or supplies that were billed to Medicare.

Medigap
A health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage.

N

National Correct Coding Initiative
Initiative that promotes correct coding by providers and suppliers and ensures that appropriate payments are made for the services they furnish.

National Coverage Determination
Sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis.

National Provider Identifier
A standard unique identifier for health care providers that will replace health care provider identifiers that are now being used in standard transactions and will eliminate the need to use different identification numbers when conducting Health Insurance Portability and Accountability Act standard transactions (e.g., eligibility and claim status inquires) with multiple plans.

Notice of Exclusions from Medicare Benefits
Notice that advises the beneficiary in advance that Medicare will not pay for certain items and services that do not meet the definition of a Medicare benefit or are specifically excluded by law.

O

Office of Inspector General
Protects the integrity of Department of Health and Human Services programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

Overpayment
Funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations.

P

Part A of the Medicare Program
Hospital insurance that helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility following a covered hospital stay, some home health care, and hospice care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians in a variety of medical settings including but not limited to the physician's office, an inpatient or outpatient hospital setting, and Ambulatory Surgical Centers; home health care; ambulance services; clinical laboratory and diagnostic services; surgical supplies; durable medical equipment and supplies; and services furnished by practitioners with limited licensing.

Part C of the Medicare Program; Medicare Advantage
A program through which organizations that contract with the Centers for Medicare & Medicaid Services provide or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Part D of the Medicare Program
Prescription drug coverage available to all beneficiaries who elect to enroll in a Prescription Drug Plan beginning on January 1, 2006.

Participating Provider or Supplier
When a provider or supplier participates in the Medicare Program and accepts assignment of benefits for all covered services for all Medicare patients.

Physician (Medicare)
Doctors of medicine and doctors of osteopathy, doctors of dental surgery or dental medicine, chiropractors, doctors of podiatry or surgical chiropody, and doctors of optometry. Must also be legally authorized to practice by a State in which he or she performs this function.

Physician Scarcity Area
U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Physician Scarcity Area Bonus Payment
A bonus payment that is made to physicians who furnish services in physician scarcity areas.

Physician Services
Services furnished by an individual licensed under State law to practice medicine or osteopathy.

Practitioner (Medicare)
Any of the following to the extent that he or she is legally authorized to practice by the State and otherwise meets Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, or registered dietician or nutrition professional.

Program Abuse
May be intentional or unintentional; directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Provider Identification Number
Individual billing number which is assigned to the Medicare Part B physician/ certain other practitioner/other supplier who furnished the service to the beneficiary, used in claims processing to identify the physician/certain other practitioner/other supplier who furnished the service to the beneficiary (rendering provider) and to identify the physician/certain other practitioner/other supplier who is submitting the claim and is to be reimbursed by Medicare (billing and pay-to providers), is currently not required if the National Provider Identifier (NPI) is submitted on Part B claims, and is assigned by Part B Carriers. Note that these numbers are being replaced by NPIs in claims processing and other Health Insurance Portability and Accountability Act standard transactions such as eligibility and claim status inquiries.

Q

Quality Improvement Organization Program
Program that consists of a national network of 53 Quality Improvement Organizations (QIO) that are responsible for each U.S. State, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to ensure that patients receive the right

care at the right time, particularly patients from underserved populations. It also investigates beneficiary complaints about quality of care and safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.

R

Remittance Advice
A notice of payments and adjustments that is sent to the provider, supplier, or biller.

Reopening
A remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record; allows the correction of minor errors or omissions without initiating a formal appeal.

S

Skilled Nursing Facility
Facility that meets specific regulatory certification requirements and primarily furnishes inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services and does not furnish the level of care or treatment available in a hospital.

Social Security Act
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Social Security Administration
Determines eligibility for Medicare benefits and enrolls individuals in Part A and/or B and the Federal Black Lung Benefit Program.

Swing Bed
Bed that a small rural hospital can use for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

T

Tax Relief and Health Care Act of 2006
Legislation enacted on December 20, 1996 that authorized, among other provisions, the Physician Quality Reporting Initiative.

Telehealth
Office and other outpatient visits, professional consultations, psychiatric diagnostic interview examinations, individual psychotherapy, pharmacologic management, End-Stage Renal Disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), and individual medical nutrition therapy furnished by an interactive telecommunications system to Medicare beneficiaries in rural areas.

U

Unique Physician Identification Number
Ordering and referring number (secondary provider) which was assigned to the physician/certain other practitioner (one number was assigned regardless of the number of practice settings he or she may have), can be used in claims processing to identify the physician/certain other practitioner who orders services or refers patients to other providers (some physicians/certain other practitioners might never bill Medicare directly), may be used in any State where the physician/certain other practitioner orders or refers, and the Centers for Medicare & Medicaid Services stopped assigning on June 28, 2007. Submitters may continue to use this number as a secondary provider identifier until May 23, 2008. Note that the National Provider Identifier will replace these numbers in claims processing and Health Insurance Portability and Accountability Act standard transactions such as eligibility and claim status inquiries.

REFERENCE B
ACRONYMS

AAA	Abdominal Aortic Aneurysm
ABN	Advance Beneficiary Notice
ADA	American Diabetes Association
AEP	Annual Coordinated Election Period
AIC	Amount in Controversy
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
AOR	Appointment of Representative
ASC	Ambulatory Surgical Center
BI	Benefit Integrity
BMM	Bone Mass Measurement
CAH	Critical Access Hospital
CC	Chief Complaint
CCN	Centers for Medicare & Medicaid Services Certification Number
CERT	Comprehensive Error Rate Testing
CF	Conversion Factor
CFR	Code of Federal Regulations
CLAS	Culturally and Linguistically Appropriate Services
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services

CNM	Certified Nurse Midwife
CNS	Certified Nurse Specialist
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CP	Clinical Psychologist
CPI	Consumer Price Index
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSR	Customer Service Representative
CSW	Clinical Social Worker
CWF	Common Working File
CY	Calendar Year
DES	Diethylstilbestrol
DIF	Durable Medical Equipment Medicare Administrative Contractor Information Form
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
DRE	Digital Rectal Exam
DSMT	Diabetes Self-Management Training

EDI	Electronic Data Interchange
E/M	Evaluation and Management
EMC	Electronic Media Claims
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GEP	General Enrollment Period
GHP	Group Health Plan
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Indices
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPI	History of Present Illness
HPSA	Health Professional Shortage Area

HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
ICD	International Classification of Diseases
ICEP	Initial Coverage Election Period
IEP	Initial Enrollment Period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LEIE	List of Excluded Individuals/Entities
LGHP	Large Group Health Plan
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCR	Medicare Contracting Reform
MEI	Medicare Economic Index
MIP	Medicare Integrity Program
MLN	Medicare Learning Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MR	Medical Review
MSN	Medicare Summary Notice

MSP	Medicare Secondary Payer
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NEMB	Notice of Exclusion from Medicare Benefits
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Nonphysician Practitioner
OEP	Open Enrollment Period
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician Assistant
PDP	Prescription Drug Plan
PE	Practice Expense
PEN	Parenteral and Enteral Nutrition
PFFS	Private Fee-for-Service
PFSH	Past, Family, and/or Social History
PIN	Provider Identification Number
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PPV	Pneumococcal Polysaccharide Vaccine
PQRI	Physician Quality Reporting Initiative
PSA	Physician Scarcity Area Prostate Specific Antigen

PT	Physical Therapy
QC	Quarters of Coverage
QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RHC	Rural Health Clinic
ROS	Review of Systems
RRA	Railroad Retirement Act
RRB	Railroad Retirement Board
RVU	Relative Value Unit
SA	State Agency
SEP	Special Enrollment Period
SGR	Sustainable Growth Rate
SHIP	State Health Insurance Program
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSN	Social Security Number
TRHCA	Tax Relief and Health Care Act of 2006
TrOOP	True Out-of-Pocket

UMWA United Mine Workers of America

UPIN Unique Physician Identification Number

VHA Veterans Health Administration

VTC Video Teleconferencing

WC Workers Compensation

REFERENCE C
CONTACT INFORMATION

Centers for Medicare & Medicaid Services

Ambulance Services Provider Center
http://www.cms.hhs.gov/center/ambulance.asp

Anesthesiologists Provider Center
http://www.cms.hhs.gov/center/anesth.asp

Appeals - Fee-for-Service
http://www.cms.hhs.gov/MLNedwebguide/05_appealsffs.asp

Beneficiary Notices Initiative
http://www.cms.hhs.gov/BNI

CMS Contact Information Directory
http://www.cms.hhs.gov/apps/contacts

CMS Forms
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp

CMS Mailing Lists
http://www.cms.hhs.gov/apps/mailinglists

Comprehensive Error Rate Testing
http://www.cms.hhs.gov/CERT

Documentation Guidelines for E & M Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Electronic Billing and EDI Transactions
http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp

HPSA/PSA (Physician Bonuses)
http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Health Insurance Portability and Accountability (HIPAA) General Information
http://www.cms.hhs.gov/HIPAAGenInfo

Home Health Agency Provider Center
http://www.cms.hhs.gov/center/hha.asp

Hospice Provider Center
http://www.cms.hhs.gov/center/hospice.asp

Hospital Provider Center
http://www.cms.hhs.gov/center/hospital.asp

Internet-Only Manuals
http://www.cms.hhs.gov/Manuals/IOM/list.asp

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles

Medicaid Program
General Information
http://www.cms.hhs.gov/MedicaidGenInfo/

Medicaid Program
Contact Information
http://www.cms.hhs.gov/apps/firststep/content/medicaid-contact.html

Medicare (beneficiaries)
http://www.medicare.gov
(800) 633-4227

Medicare Advantage
General Information
http://www.cms.hhs.gov/HealthPlansGenInfo/

Medicare Contracting Reform
http://www.cms.hhs.gov/MedicareContractingReform

Medicare Coordination of Benefits
http://www.cms.hhs.gov/COBGeneralInformation

Medicare Coordination of Benefits Contractor
(800) 999-1118

Medicare Coverage Center
http://www.cms.hhs.gov/center/coverage.asp

Medicare Coverage Database
http://www.cms.hhs.gov/mcd/search.asp

Medicare Fee-for-Service Provider Resource Center
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network
http://www.cms.hhs.gov/MLNGenInfo/

Medicare Modernization Update
http://www.cms.hhs.gov/MMAUpdate

Medicare Provider-Supplier Enrollment
http://www.cms.hhs.gov/MedicareProviderSupEnroll/

Medicare Provider-Supplier Enrollment Contacts
http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

Medicare Publications (beneficiaries)
http://www.medicare.gov/publications/home.asp

National Correct Coding Initiatives Edits
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov

National Provider Identifier Standard
http://www.cms.hhs.gov/NationalProvIdentStand

Open Door Forums
http://www.cms.hhs.gov/OpenDoorForums

Partner Center
http://www.cms.hhs.gov/center/partner.asp

Pharmacists Partner Center
http://www.cms.hhs.gov/center/pharmacist.asp

Physician Fee Schedule
http://www.cms.hhs.gov/PhysicianFeeSched

Physician Fee Schedule Look-Up Tool
http://www.cms.hhs.gov/PFSlookup/

Physicians Partner Center
http://www.cms.hhs.gov/center/physician.asp

Physicians Regulatory Issues Team
http://www.cms.hhs.gov/PRIT

Practice Administration Information Resource Center
http://www.cms.hhs.gov/center/practice.asp

Practicing Physicians Advisory Council
http://www.cms.hhs.gov/FACA/03_ppac.asp

Prescription Drug Coverage
General Information
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
http://www.cms.hhs.gov/PrivateFeeforServicePlans

Provider Call Center Toll-Free Numbers Directory
http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp

Public Affairs Center
http://www.cms.hhs.gov/center/press.asp

Quality Improvement Organizations
http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates

Regional Office Overview
http://www.cms.hhs.gov/RegionalOffices

Regulations & Guidance
http://www.cms.hhs.gov/home/regsguidance.asp

Resident Training Listserv
http://www.cms.hhs.gov/apps/mailinglists

State Health Insurance Programs
http://www.cms.hhs.gov/Partnerships/10_SHIPS.asp

Telehealth
http://www.cms.hhs.gov/Telehealth

Therapy Services
http://www.cms.hhs.gov/TherapyServices

Other Organizations

Administration on Aging
http://www.aoa.gov

Agency for Healthcare Research and Quality
http://www.ahrq.gov

American Medical Association (ICD-9-CM, CPT, and HCPCS publications)
http://www.amapress.org
(800) 621-8335

Commerce Clearing House
http://www.cch.com
(800) 835-5224

Coordination of Benefits Contractor
(800) 999-1118

Financial Institutions Examination Council
http://www.ffiec.gov/default.htm

General Services Administration
Excluded Parties List System
http://www.epls.gov

Health and Human Services Office of Inspector General
http://www.oig.hhs.gov

Health and Human Services Office of Inspector General
List of Excluded Individuals/Entities
http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

Health and Human Services Office of Inspector General
National Hotline
(800) 447-8477

Health and Human Services Office of Minority Health
Cultural Competency Continuing Education Programs
http://thinkculturalhealth.org

Health Resources and Services Administration
http://www.hrsa.gov

National Technical Information Service
http://www.ntis.gov/help/subscriptions.asp
(800) 363-2068

National Uniform Billing Committee
http://www.nubc.org/guide.html
(800) 242-2626

Railroad Retirement
Electronic Claims Processing Information
(866) 749-4301

Railroad Retirement Board
(800) 808-0772

Social Security Administration
http://www.ssa.gov/
(800) 772-1213

United Mine Workers
Electronic Claims Processing Information
(800) 215-4730

U.S. Census Bureau
http://www.Census.gov

U.S. Department of Health and Human Services
http://www.hhs.gov

U.S. Government Printing Office
Code of Federal Regulations
http://www.gpoaccess.gov/cfr/index.html

U.S. Government Printing Office
U.S. Government Bookstore
http://bookstore.gpo.gov
(800) 512-1800