Joe Broseker, Deputy Director of the Provider Billing and Education Group at the Centers for Medicare & Medicaid Services.

Hello, I'm Joe Broseker, Deputy Director of the Provider Billing and Education Group at the Centers for Medicare & Medicaid Services. I'm pleased to welcome you to this broadcast.

The purpose of this broadcast is to acquaint you with the new ambulance fee schedule. Specifically, on April 1, 2002 the Centers for Medicare & Medicaid Services establishes a fee schedule to pay for ambulance services furnished to Medicare beneficiaries.

This fee schedule was mandated by Congress in the Balanced Budget Act of 1997. That legislation, specifically § 4531(b)(2) of the BBA, added a new section 1834(l) to the Social Security Act that required CMS to enter into negotiated rulemaking with the ambulance service industry to establish a national fee schedule. In doing so, CMS was required to:

- establish mechanisms to control increases in expenditures for ambulance services as a benefit under Part B of the Medicare program;
- establish definitions for ambulance services that link payments to the types of services furnished;
- limit payment for ambulance covered services to the lower of actual billed charges or the ambulance fee schedule amount;
- consider appropriate regional and operational differences and adjustments to payment rates to account for inflation and other relevant factors; and
- require that payment for ambulance services be made only on an assignment-related basis; and,
- phase in the fee schedule in an efficient and fair manner.

This fee schedule replaces Medicare's existing ambulance payment methodologies (i.e., retrospective reasonable cost reimbursement to providers and reasonable charge payment to suppliers). Under the fee schedule, ambulance service providers and suppliers will be paid a pre-established fee for each type of ambulance service provided. This is similar to the method of payment Medicare has adopted for hospitals, nursing homes, home health agencies and other health care providers.

As implemented by regulation published on February 25, 2002, the fee schedule will be phased-in over a five-year period. During this transition period, ambulance services will be paid on the basis of a blended rate. The blended rate comprises a fee schedule portion and a portion based on either a provider's historical reasonable cost or a supplier's historical reasonable charge. In 2002 the blend will be 20 percent of the fee schedule and 80 percent of the reasonable cost or charge. In 2003, the blend will be 40 versus 60 percent; in 2004, the blend will be 60 versus 40 percent; and in 2005, the blend will be 80 percent fee schedule and 20 percent reasonable cost or charge. Beginning in 2006, payment will be based entirely on the fee schedule.

Under the ambulance fee schedule there are seven categories of ground ambulance services, which include both land and water transportation, and two categories of air ambulance services. The seven categories of ground ambulance services are: 1) Basic Life Support (BLS); 2) Basic Life Support - Emergency BLS-E); 3) Advanced Life Support, Level 1 (ALS1); 4) Advanced Life Support, Level 1 - Emergency (ALS1-E); 5) Advanced Life Support, Level 2; (ALS2); 6) Paramedic Intercept; and 7) Specialty Care Transport (SCT). The two categories of air ambulance services are fixed wing (airplane) and rotary wing (helicopter). Medicare pays for such services when medically necessary.

These categories of service were established through negotiations with the ambulance industry to reflect distinctions in types of services furnished to beneficiaries. I'll now briefly describe each category of service.

Basic Life Support (BLS) services is a ground transportation service and medically necessary supplies and services. BLS is defined in the National EMS Education and Practice Blueprint for EMT - Basic, and includes establishing a peripheral intravenous line.

Basic Life Support - Emergency (BLS-E) is a BLS service in the context of an emergency response. An emergency response is one that, at the time the ambulance is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing a beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

Advanced Life Support, Level 1 (ALS1) is ground transportation and medically necessary supplies and services, including at a minimum either an assessment by an advanced life support provider or supplier or one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT - Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as procedure beyond the scope of an EMT - Basic as defined in the National EMS Education and Practice Blueprint.

Advanced Life Support, Level 1 - Emergency (ALS1-E) is an ALS1 service furnished in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2) is ground transportation and medically necessary supplies and services, including at a minimum the administration of three or more different medications by intravenous push/bolus or by continuous infusion (excluding crystalloid, hypotonic, isotonic and hypertonic) and the provision of at least one of the following ALS procedures: manual defibrillation or cardioversion, Endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway and intraosseous line. (Hypertonic consists of Dextrose, Normal Saline and Ringer's Lactate.)

Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. No mileage is paid for this benefit. For a description of these services, carriers and fiscal intermediaries should see program memorandum B-99-12, dated March 1999 and program memorandum B-00-01, dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997. Suppliers and providers should contact their carrier or intermediary for additional information.

Specialty care transport (SCT) is ground transportation and medically necessary supplies and services for a critically injured or ill beneficiary. SCT is a level of inter-facility service provided beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. SCT is appropriate when a beneficiary's condition requires ongoing care during the transport that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training).

Fixed wing air ambulance service is transportation by airplane (and medically necessary supplies and services). Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may

be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary wing air ambulance service is transportation by a helicopter (and medically necessary supplies and services). Like a fixed-wing ambulance service, rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

With that brief overview, we are going to turn now to several CMS subject matter experts to give you a little more insight into how the fee schedule will operate.

To discuss various aspects of the ambulance fee schedule, I have with me today, several CMS ambulance experts. First, Dolores Crujeiras, a Health Insurance Specialist in the Division of Supplier Claims Processing whose expertise is in developing billing procedures for Medicare suppliers. Dolores will provide information today on the impact of the fee schedule on suppliers. Next we have Nicole Atkins, a Health Insurance Specialist in the Division of Institution Claims Processing. Nicole's expertise is in developing billing procedures for Medicare providers. Nicole will give us some information today on the impact on Medicare providers. Finally, we have Robert Niemann, a Health Insurance specialist in the Division of Outpatient Care. Bob is the agency's acknowledged expert on ambulance payment policy and, along with a team of other CMS analysts including Nicole Atkins and Dolores Crujeiras who are also a part of this panel, developed the final rule for the ambulance fee schedule. Dolores lets start with you.

Joe: When will mandatory assignment for suppliers be affective?
Dolores: Joe, mandatory assignment for suppliers begins with services with dates of service on or after April 1, 2002. Suppliers may use modifiers GA, GY and GZ if the supplier believes that a service might not be covered by Medicare. However, that claim must still be an assigned claim.

Joe: Nicole, how about assignment of claims for providers?
Nicole: Providers are already required to accept assignment.

Joe: Bob, let me ask you, how should an emergency dispatch be billed?
Bob: Well Joe, depending upon the specifics of the situation any one of several levels of service may be appropriate. There is BLS-Emergency, ALS1-Emergency, ALS2, and air ambulance. Note that only the first 2 levels of ground ambulance have an "emergency" level specified. Other levels of service are not broken out by "emergency" vs. "non-emergency". If a call comes through a "911" service or the equivalent, and the ambulance responded immediately to the call, then it is paid at the "emergency" rate, provided, of course, that an ambulance transport was furnished and that it was medically necessary to be transported by ambulance.

Joe: Bob, I'm sure providers and suppliers would like to know if they can bill for drugs?
Bob: Joe, Under the Fee schedule the answer is no. There is no separate Medicare drug benefit under the ambulance benefit. Payment for all supplies, including all drugs, is included in the base rate payment. However, under the transition rules, if

an ambulance supplier had been billing separately for supplies, then they may continue to bill separately until the fee schedule is fully implemented.

Joe: And are oxygen, saline and aspirin considered drugs for ALS2?
Bob: No, they are not. ALS2 drugs are those requiring administration by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions.

Examples of drugs that are not ALS2 drugs include Dextrose, Normal Saline and Ringer's Lactate.

Joe: Thank you Bob. Nicole, would you tell us about the new HCPCS codes?
Nicole: Sure Joe. Providers and suppliers should continue to report the HCPCS codes that were introduced in January 2001. However, the two mileage codes A0380 and A0390 will be invalid for dates of service after March 31, 2002. Effective for claims with dates of service on or after April 1, 2002, providers and suppliers must report HCPCS code A0425 for ground mileage. We have deleted HCPCS code Q3017 and introduced two new codes to handle provisions defined in the final regulation. These codes, Q3019, which is ALS Vehicle Used for emergency transport but no ALS service furnished and Q3020 which is ALS Vehicle used for non-emergency transport but no ALS service furnished, will be billable beginning April 1, 2002.

Joe: Dolores, how about condition codes. How do they have to be used?
Dolores: Joe, in the Notice of Proposed Rule we identified condition codes. We have changed that title to condition indicators. These condition indicators are not required. Suppliers and providers may use them if they wish. Using a condition indicator does not assure payment for the claims since that indicator is not sufficient documentation to show that the service was reasonable and necessary. Medicare intermediaries and carriers may request additional documentation for review to make this determination.

Joe: Bob, how do the contractors pay when there are multiple patients with a single transport?
Bob: Well, again Joe, it depends upon the number of patients, i.e., Medicare, Medicaid and privately insured patients. For two patients, each Medicare beneficiary benefit is paid based on 75 percent of the applicable base rate for that same situation if the patient was alone plus 50% of the mileage rate. For three or more patients, each Medicare beneficiary benefit is paid based on 60 percent of the applicable base rate for that same situation when the beneficiary is alone plus the applicable mileage rate divided by the number of patients.

Joe: Dolores, for suppliers, should a GM modifier be used when transporting multiple patients?
Dolores: Yes Joe. The GM modifier is used to identify a service where there were multiple patients on one ambulance trip. Suppliers must use this modifier to identify all the beneficiaries who were transported. The final rule contains the formula to use to determine the payment for a multiple transport. We will have instructions available soon.

Joe: Thank you Dolores. Nicole, what about for providers, how should they report situations where multiple patients are transported simultaneously?
Nicole: CMS is currently seeking a way to indicate when a multiple patient transport has occurred and how many patients were transported at the same time. Until instructed otherwise, institutional ambulance providers should continue to report these situations the way they have been reporting them. Additional instructions will be forthcoming.

Joe: Thank you Nicole. Bob, how is mileage paid and is there a special provision for payment of mileage?

Bob: Joe, mileage is paid under the fee schedule as a payment per mile. The payment rate varies by the type of ambulance and whether the trip originated in a rural area. The different rates are: Urban ground rate and that applies to both ALS and BLS ground transports. Mileage that is rural and is in excess of 50 miles. Mileage that is rural from 1 to 17 miles have a 50 % increase and rural miles that are between 18-50, have a 25% increase over the ground base rate. The air mileage rates are for fixed wing and rotary wing, and each has a 50% increase for all rural mileage.

I would also like to make another point about mileage payment. Under the reasonable charge payment system, there were any of methods that could be used for billing ambulance services. For 2 of those methods, mileage could not be billed separately from the base rate for the transport. The suppliers that use either of those two methods, should now develop a charge for mileage and bill for mileage separately on the medicare claim. In that way they may receive payment for mileage under the Fee Schedule portion of the blended rate during the transition period. If the supplier does not enter a separate charge for mileage on the claim, the supplier will not be paid the Fee Schedule portion of the blended rate for mileage.

Joe: Now, do local and state ordinances have an effect on Medicare reimbursement? For example, in the proposed rule, CMS was no longer going to pay for an ALS vehicle when only BLS level services were provided?

Bob: Well Joe, we do look to State regulations in terms of the certification of ambulances, that is, States or local jurisdictions set the requirements for who is licensed to furnish ambulance services. Under the Fee Schedule local ordinances do not affect the level of payment. For example, some local jurisdictions require that all ambulance vehicles be ALS vehicles. However, during the transition period we will continue to pay for ALS vehicles in these situations for the "old" portion of the blended transition period payment. We have established 2 new temporary "Q" codes (Q3019 and Q3020) to bill for these during the transition period.

Joe: Nicole, should we continue to put the point of pick-up zip code on the claim form?

Nicole: Yes we use the zip codes to determine the payment locality for the service. It is also used to determine whether the claim should be paid as a rural or urban service. Our requirement is a claim may have only one zip code. This means if an ambulance has a round trip, that round trip can be coded on one claim only if the point of pick up for each transport is in the same zip code. If the two legs of a round trip are in different zip codes, there must be two claims submitted.

Joe: A question for you Delores, can suppliers change payment methods?

Dolores: Suppliers may not change methods once we begin using the ambulance fee schedule. There were carriers who had suppliers using multiple methods. Those suppliers were advised to select one method for the transition to the fee schedule. Carriers made adjustments to those suppliers' reasonable charge profiles. Now any new suppliers will select one method that is supported by the carrier. The reasonable charge will be determined under current rules for the new supplier. We suggest that they use method two since with full fee schedule, all ambulance suppliers will be using method two.

Joe: Nicole, are their special provisions for Critical Access Hospitals?

Nicole: Section 205 of the Benefits Improvement Protection Act of 2000 provided that Critical Access hospitals, or entities owned and operated by them, are paid for ambulance services based on reasonable cost if there is no other ambulance provider or supplier within a 35-mile drive. As a result, these entities are exempt from the ambulance fee schedule and exempt from the cost per trip limit established by the Balanced Budget Act of 1997 (implemented by Program memorandum A-98-2).

Joe: Now, does this provision affect both all inclusive and standard method Critical Access Hospitals?
Nicole: This provision affects all Critical Access Hospitals billed on an 85X type of bill.

Joe: Bob has the definition for Advanced Life Support changed?
Bob: Yes, Joe, for ALS2 for example, in the proposed rule published on Sep 12, 2000, we stated that in order to qualify for an ALS2 level of service, three different medications must have been administered **plus** at least one of the following ALS2 procedures: First,
(1) Manual defibrillation or cardioversion.
(2) Endotracheal intubation.
(3) Central venous line.
(4) Cardiac pacing.
(5) Chest decompression.
(6) Surgical airway.
(7) Intraosseous line.

In the Final rule published on Feb 27, 2002, we state that ALS2 means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push or bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions examples of these, (Dextrose, Normal Saline, Ringer's Lactate); **or** transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures and then we repeat the same list of services that I mentioned in the first pat of my answer. Sot he difference between these two is the fact that in the proposed rule we said "and" but in the final rule we qualified that or clarified that by saying "or" rather than "plus". We also clarified that 3 separate administrations of the same ALS 2 drug qualify for ALS 2 payment. There was also some confusion on the definition of ALS1 level of care. In the proposed rule the proposed regulation's text was correct, but the preamble discussion was inconsistent with the regulation text. We have clarified that for ALS1 level payment, an ALS assessment **or** another ALS level intervention must be furnished.

Joe: Now how about the definition for Advanced Life Support Assessment changed?
Bob: Yes, that has changed also. In the proposed rule published on Sep 12, 2000, we said that an ALS service is an assessment performed by an ALS crew that results in the detemination that the patient's condition requires an ALS level of care, even if no other ALS intervention is actually performed. In the Final rule, which again was published Feb 27, 2002, the defintion was changed to: an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. The difference is that an ALS assessment pertains only to an emergency and need not result in the determination that the patient's condition actually requires an ALS level of care.

Joe: Thank you Bob. Dolores, what is acceptable documentation for physician certification for suppliers?
Dolores: Well, the CMS policy requires a physician signature on PCS or other health care professional as noted in the final rule. If no signature can be obtained and the supplier has attempted to get signature by mail, we will accept any United States Postal Service form that notes that a letter has been sent to an address. This is not limited to the return receipt service. CMS policy states there is documentation that an attempt has been made to obtain the signature of the physician.

Joe: Bob, how will prices be updated during the transition to the new fee schedule?
Bob: Every year CMS will announce thru notice in the Federal Register what the new fee schedule amounts are. This will reflect the ambulance inflation factor prescribed by law Consumer Price Index for Urban consumers and any other adjustments that correct for any significant differences between our original assumptions in setting the FS amounts and actual experience. Also, the Medicare carriers and intermediaries will use the ambulance inflation factor to update the payment allowance from the "old" portion of the blended payment during the transition period.

Joe: Dolores, one final question, will reading the comments and responses to the regulation help carriers respond to suppliers?
Dolores: Yes. Reading the final regulation provides background and insight into the items in the final. This final regulation provides the comments from interested parties and our response to them. These comments present suggestions for modifications to the language of the regulation. Our comments explain why we are including or excluding an item from the regulation.

Joe: I'd like to thank our panelist for participating today and providing such important information regarding the new ambulance fee schedule. We also visited with Danny Platt of LifeStar Ambulance, an ambulance supplier and took a trip out to Martins airport, one of the many locations where the ambulance rotary wing or helicopters are located. We discussed the impact of implementing the new fee schedule. Let's take a look.

Danny Platt, LifeStar Response: Currently the ambulance suppliers are may or not accept assignment. After April 2002 they are required to accept assignment on all claims.

Currently payment for services is based upon the location the ambulance is dispatched from. After April 2002 payment for services will be based on the location that the patient is picked up from, the zip code.

Most importantly I'd like to say that beneficiaries need to be educated on what is a covered service and what is medically necessary for that service.

Here at CMS we know that when payment systems are implemented, our customers often have questions and would like to know just what avenues are available from CMS for obtaining additional information. I'd like to introduce Cheryl Barton, a Health Insurance Specialist here at CMS who works in the Division of Provider Education and Training. As a member of that division, Cheryl develops education campaigns to educate the Medicare provider and supplier community on various payment systems.

Cheryl: Thank you Joe. We thought it would be helpful if we took a few minutes to share some important information with you regarding preparing for the April 1, 2002 implementation date of the ambulance fee schedule.

We have revised the November 2000 edition ambulance-training manual to include information contained in the February 27, 2002 final rule. There is one manual for carriers and suppliers and another manual for fiscal intermediaries (FIs) and providers. These manuals can be found on our ambulance quick reference guide site at www.cms.hhs.gov/medlearn/refamb.asp. These manuals contain a wealth of information on updates and changes to the fee schedule.

On the same web site, you will find a link to frequently asked questions and answers as well as links to program memoranda, a press release, a fact sheet, the final rule and the CMS ambulance listserv. Just as a matter of reference, a listserv is an electronic subscription service. Interested parties may subscribe to our listservs using an email address. When information becomes available on ambulance or other Medicare issues, CMS uses these listservs to disseminate information in a timely manner. This helps us to be sure that we are giving a consistent message regarding

any issue. We encourage you to subscribe to the ambulance listserv as well as other listservs that we have available www.cms.hhs.gov/medlearn/listserv.asp.

As another source of reference, we will also make available, free of charge, video copies of today's broadcast. The video in conjunction with the revised manual are a great source of information. Copies may be obtained by sending an email to medlearn@cms.hhs.gov. Your email should include your name, full mailing address and telephone number. Please be sure and secure your copy of today's broadcast.

For suppliers and providers who have questions or concerns regarding the fee schedule, please contact your Medicare carrier or fiscal intermediary for assistance. We have provided a web site that lists numbers to contact your carrier or fiscal intermediary as well as direct links to their websites. That information is found at www.cms.hhs.gov/medlearn/tollfree.asp.

Carriers and FIs with questions should report any concerns or problems to your regional office contact.

We believe that providing you with this broadcast, the revised training manual and all of the information contained on our web site will help you be prepared for the April 1, 2002 implementation date of the ambulance fee schedule.

While I have your attention today, I would also like to inform you of other provider education products you may find useful that we have available here at CMS.

We recently revised the Medicare Resident Training manual. The manual is now called the Medicare Resident and New Physician's training manual. This manual was developed to give Medicare physicians and residents an overview of the various Medicare programs. Other publications we have available include a manual on Women's Health, Adult Immunization and Fraud and Abuse. We also offer several video tapes on topics such as Medicare Physician and Resident training, the Health Insurance Portability and Accountability Act or HIPPA, Home Health PPS, Women's Health, Adult Immunization and Fraud & Abuse. Along with the manuals and the videos, we also offer training cd-roms. The cd-roms available are Medicare physician and resident training, encounter data and a multi-media cd that consists of a training course on such issues as Front Office Management, the Medicare home health benefit, Medicare Secondary Payer as well as others. A complete listing of these publications can be found on our web site and are offered to you free of charge. To obtain your copy of any of the products I mentioned today, just send an email to medlearn@cms.hhs.gov. Again, include your name, full mailing address and phone number as well as the products you are requesting.

I hope that I have provided you with some avenues for obtaining a great deal of information regarding the fee schedule as well as other Medicare initiatives. Please take some time to analyze the impact this fee schedule will have on your processes, your systems and your relationship with your business partners. Be sure and work together to ensure an smooth transition to the fee schedule.

Joe: Thank you Cheryl for that information. In summary, we have provided you with an overview of the ambulance fee schedule as well as some questions and answers that we felt suppliers and providers would have the most concern about. We hope that we were able to give you information today to supplement the wealth of information available on the new ambulance fee schedule. We encourage you to visit CMS and HHS web sites for additional information. We anticipate that you may have more questions following this broadcast. We have available for you today, a toll free number that you may call and speak with one of our ambulance experts regarding policy, billing and provider education. This service will be available for a half-hour following this broadcast. That toll free number is 1-800-953-2233.

Thank you for joining us today. I am Joe Broseker and on behalf of the CMS team, we look forward to assisting you with any concerns you may have with implementing the new ambulance fee schedule.

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Special Thanks To:
LifeStar Response

Danny Platt
Rick Leonard/STAT Medevac
Johns Hopkins Hospital
Dennis W. Jones/STAT Medevac
Francis McCloskey/Pilot
Danielle Stokes/EMT-B
Michelle Bundy/EMT

Thanks to CMS Staff

Stewart Streimer
Valerie Hart
Parashar Patel
Debbie Bonney
Paul Haugen
Robin Phillips
Bill McQueeney
Danford Layne
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