hcpro | boot camps

Medicare Rural Health Clinic Version

KEY CONCEPTS OUTLINE
Module 4: Supplemental Review of Medicare Overview, Contractors, Research, and Resources

I. The Four Parts of Medicare

A. Medicare Part A

   1. Part A covers inpatient care, including:

      a. Hospital care at a general acute care hospital, Critical Access Hospital (CAH), Inpatient Rehabilitation Facility, Inpatient Psychiatric Facility, or Long Term Acute Care Hospital (LTCH);

      b. Care at a Religious Nonmedical Health Care Institution;

      c. Skilled Nursing Facility (SNF) care;

      d. Home Health care (under a home health plan of care);

      e. Hospice care. <Medicare.gov, "What Part A covers" website>

   2. These facilities are referred to as "providers" under the Medicare regulations. <42 *C.F.R.* 400.202>

   3. The beneficiary generally doesn't pay a premium for Part A if they, or their spouse, paid Medicare taxes. <Medicare.gov, "Part A costs" website>

      a. If an individual doesn't qualify for premium free Part A benefits, they can purchase them. To purchase Part A, the beneficiary must generally also purchase Part B and may have to meet certain other requirements. <Medicare.gov, "Part A costs" website>

   4. Institutional providers bill Part A services to the A/B Medicare Administrative Contractor (MAC) using the UB-04/837I claim format. <*Medicare Billing: 837I and Form CMS-1450* Fact Sheet>

      a. Course note: The A/B MAC is discussed later in this outline. The UB-04/837I format is discussed in a later module.

B. Medicare Part B

1. Part B covers inpatient, outpatient, and medical care, including but not limited to:

   a. Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services;

   b. Preventative services provided to outpatients and inpatients;

   c. Physician and other professional services, including outpatient therapy;

   d. Outpatient hospital diagnostic and non-diagnostic (therapeutic) services;

      i. Note: MACs often place policies for these services under Part A on their website even though these services are covered under Part B.

   e. Clinical Diagnostic Laboratory services; and

   f. Durable Medical Equipment (DME). <Medicare.gov, "What Part B covers" website>

2. These services can be provided by institutional "providers" or "suppliers", including physicians and other non-institutional providers. <42 *C.F.R.* 400.202>

3. The beneficiary generally pays a premium for Part B. <Medicare.gov, "Part B costs" website>

> *Medicare beneficiaries may have both Part A and Part B or just Part A or just Part B. Enrollment should be verified prior to billing.*

4. Most professional services covered under Medicare Part B are billed to the A/B MAC on the CMS 1500/837P claim format.

   a. Although RHC services are primarily professional services covered under the Medicare Part B benefit, most RHC services are billed to the MAC on the institutional UB-04//837I claim format using the appropriate bill type (071X). <*Medicare Billing: 837I and Form CMS-1450* Fact Sheet>

      i. Consequently, the MAC will often place policies for RHC services on the Part A portion of their website.

   b. The technical portion of certain diagnostic services (including laboratory services) performed by a provider-based RHC are billed by the main provider to the MAC on the UB-04/837I claim format.

    c. The technical portion of certain diagnostic services (including laboratory services) performed by an independent RHC are billed by the RHC to the A/B MAC on the CMS 1500/837P claim format.

C. Medicare Part C

    1. Medicare Part C is an alternative to traditional fee-for-service Medicare Part A and B. Private insurance companies offer Part C in the form of Medicare Advantage (MA) plans. <Medicare.gov, "Your Medicare coverage choices" website>

    2. MA plans must cover all services traditional Medicare covers, except hospice care. <Medicare.gov, "What Medicare health plans cover" website>

        a. Traditional fee-for-service Medicare covers hospice care for beneficiaries covered by MA Plans. <Medicare.gov, "What Medicare health plans cover" website>

    3. MA plans may cover additional services, including vision, hearing, dental, or preventative services not covered by traditional fee-for-service Medicare. <Medicare.gov, "What Medicare health plans cover" website>

    4. MA plans most commonly take the form of Health Maintenance Organizations (HMOs). They may also be Preferred Provider Organizations (PPOs), Private Fee-For-Service (PFFS) plans, or Special Needs Plans (SNPs). <Medicare.gov, "Different types of Medicare Advantage Plans" website>

    5. MA Plans pay according to their contract with the provider or, if they are not contracted, they must generally pay the hospital at least the traditional Medicare payment rate. <*MA Payment Guide for Out of Network Payments, 4/15/2015 Update*>

        a. Medicare publishes a very helpful guide for payments by MA plans to out of network providers on their "Provider Payment Dispute Resolution for Non-Contracted Providers" website.

> *Link: Medicare Advantage Out of Network Payment Guide under Medicare-Related Sites - General*

D. Medicare Part D

    1. Part D covers prescription drugs for Medicare beneficiaries. Part D plans are designed to cover drugs obtained from a retail pharmacy. <*How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Setting*>

        a. Part D may cover drugs not covered under Part B and provided in an RHC.

II. Medicare Contractors

A. The Centers for Medicare and Medicaid Services (CMS) use multiple functional contractors to perform the functions necessary to administer the Medicare program.

B. Part A/B Medicare Administrative Contractors (MACs)

1. MACs are Medicare contractors who perform all core claims processing functions and act as the primary point of contact for providers and suppliers for functions such as enrollment, coverage, billing, processing, payment, and auditing. <CMS.gov, "What is a MAC" website>

   a. MACs publish substantial claims processing, billing, and coding guidance on their websites, including medical review and documentation guidelines, coverage policies, and appeals and audit information.

   > Tip: Medicare contractors sometimes refer to hospital outpatient services as "Part B of A" or simply Part A outpatient services. Policies and guidance for outpatient services are found on MAC Part A websites even though these services are covered under Part B.

2. There are 12 Part A/B MACs, designated by either a letter or number. <Medicare Administrative Contractors (MACs) As of October 2017; see "A/B Jurisdiction Map as of October 2017">

   > In 2010, CMS began consolidating the original 15 MAC jurisdictions (designated by numbers) into 10 consolidated MACs (designated by letters). In 2014, after consolidating 12 jurisdictions, CMS discontinued the consolidation leaving four numbered jurisdictions (J5, J6, J8, and J15).
   >
   > **Link: Medicare Administrative Contractors (MACs) Jurisdictions under Medicare-Related Sites - General**

   a. Note: For a provider-based RHC, the host provider's MAC has jurisdiction when the RHC is located in a different jurisdiction. <Medicare Claims Processing Manual, Chapter 1 § 10.2>

   b. CMS publishes a map with state by state contractor information.

   > **Link: Medicare Contractor Interactive Map under Medicare-Related Sites - General**

C. Recovery Audit Program

1. CMS identified four Part A/B Recovery Audit jurisdictions and one national jurisdiction for DMEPOS/Home Health/Hospice claims. <See "A/B Recovery Audit Program Regions">

> *CMS changed terminology from Recovery Audit Contractor (RAC) to Recovery Auditors and Recovery Audit Program.*

2. CMS contracts with one Recovery Auditor for each jurisdiction, who is paid a contingency fee based on identified overpayments and underpayments. <CMS.gov, "Medicare Fee for Service Recovery Audit Program" website>

> *Current Recovery Auditors and their recovery percentages as of October 31, 2016:*
> - *Region 1 (Northeast/Great Lakes): Performant Recovery, Inc., 8.38%*
> - *Region 2 (Midwest/Southwest): Cotiviti, LLC, 6.74%*
> - *Region 3 (Southeast): Cotiviti, LLC, 7.61%*
> - *Region 4 (West/Mid-Atlantic): HMS Federal Solutions, 17.46% (7.46%?)*
> - *Region 5 (National): Performant Recovery, Inc., 8.00%*

3. CMS publishes proposed and approved audit topics on their website.

> ***Link: Recovery Audit Program under Medicare-Related Sites - General***

4. Recovery Auditors have a three year look back period, based on the claims paid date, unless CMS specifies a different period. <"Medicare Fee-for-Service Recovery Audit Program, Additional Documentation Limits For Medicare Institutional Providers (i.e. Facilities)", updated 5/1/19>

5. Recovery Auditors can make a limited number of Additional Documentation Requests (ADRs) for medical records from providers each 45 day period. <"Medicare Fee-for-Service Recovery Audit Program, Additional Documentation Limits for Medicare Institutional Providers (i.e., Facilities)", updated 5/1/19>

   a. For details on how ADR limits are calculated, refer to the Resources page of the Recovery Audit Program site in the document link labeled ADR Limits-

D. Unified Program Integrity Contractors (UPICs)

1. Effective April 1, 2019, Unified Program Integrity Contractors (UPICs) combine and integrate the functions of the Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs) and Medicaid

Integrity Contractors (MICs). <CMS.gov, Review Contract Directive Interactive Map Page>

2. The UPICs perform integrity related activities (e.g. investigations and audits) associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi) in five geographic jurisdictions. <CMS.gov, Review Contract Directive Interactive Map Page

> *In performing fraud and abuse functions, UPIC may:*
> - *Conduct investigations and perform medical review*
> - *Perform data analysis*
> - *Request medical records and documentation*
> - *Conduct interviews with beneficiaries, complainants, or providers*
> - *Conduct site verification or onsite visits*
> - *Identify the need for a prepayment or auto-denial edit*
> - *Share information with other UPICs/ZPICs*
> - *Institute a provider payment suspension*
> - *Refer cases to law enforcement to consider civil or criminal prosecution*
>
> *Unified Program Integrity Contractor page, Noridian website*

E. Comprehensive Error Rate Testing (CERT) Program

1. CMS contracts with CERT contractors to perform audits to measure the error rate of Medicare paid claims. <CMS.gov, "Comprehensive Error Rate Testing" website>

2. The CERT contractor uses a statistically random sample of approximately 50,000 claims to determine a national improper payment rate for the Medicare program. <CMS.gov, "Comprehensive Error Rate Testing" website>

3. The CERT contractor assigns of improper payment categories:

a. No Documentation

b. Insufficient Documentation

c. Medical Necessity

d. Incorrect Coding

e. Other

             i. Examples include duplicate payment error and non-covered or unallowable service

F. Supplemental Medical Review Contractors (SMRCs)

    1. CMS contracts with SMRCs to perform and provide support for a variety of tasks, including nationwide medical review audits aimed at lowering improper payment rates by conducting reviews focused on vulnerabilities identified by CMS. <CMS.gov, "Supplemental Medical Review Contractor" website>

    2. SMRC's conduct medical reviews selected based upon multiple sources of information including, but not limited to:

        a. CMS identified vulnerabilities;

        b. OIG/GAO (Office of Inspector General/Government Accountability Office) identified issues; and

        c. Comprehensive Error Rate Testing (CERT) Errors. <Medicare Program Integrity Manual, Chapter 1 § 1.3.1>

G. Quality Improvement Organizations (QIOs)

    1. Beneficiary and Family Centered Care QIOs (BFCC-QIOs) manage beneficiary complaints and quality of care reviews, including beneficiary discharge appeals. <CMS.gov, "Quality Improvement Organizations" website; CMS.gov, "Inpatient Hospital Reviews" website; 80 *Fed. Reg.* 39350-53>

    2. CMS contracts with two BFCC-QIOs, KEPRO and Livanta, to provide services in 10 distinct areas designated by CMS. For details, refer to the QIO map included in the materials behind the outline. <See "QIO MAP">

    3. Short Stay Reviews

        a. One of the QIOs, Livanta, was awarded a national contract to conduct short stay reviews and higher weighted DRG reviews in all QIO jurisdictions.

            i. Livanta has posted a schedule of weeks throughout 2022 it will request medical records for short stay reviews. <See Livanta National Medicare Claim Review Contractor, Short Stay Review webpage>

H. Qualified Independent Contractor (QIC)

    1. QICs conduct the second level of appeal if the MAC denies the providers first level appeal. <CMS.gov, "Second Level of Appeal: Reconsideration by a Qualified Independent Contractor" website>

III. Independent Government Entities

   A. Departmental Appeals Board (DAB)

      1. DAB is an agency within the Department of Health and Human Services that provides independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions. <DAB Website, Background>

      2. The two primary divisions of DAB with respect to Medicare disputes and appeals are:

         a. Office of Medicare Hearings and Appeals (OMHA);

            i. The Administrative Law Judges (and attorney advisors) are employed directly by the Office of Medicare Hearings and Appeals (OMHA).

            ii. ALJs issue third level appeal decisions following an appeal of a decision of the QIC.

         b. Medicare Appeals Council (often referred to as either "MAC" or the Council)

            i. The Council provides the final administrative review (fourth level of appeal) of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers appealed from the ALJs.

   B. Department of Health and Human Services Office of Inspector General (OIG)

      1. The DHHS OIG is the largest inspector general's office in the Federal Government, with most of their resources directed at oversight of the Medicare and Medicaid programs. <About OIG, HHS OIG website>

      2. The DHHS OIG conducts nationwide audits, investigations, and evaluations; publishes an annual work plan of audit activity; provides cost saving and policy recommendations; and develops and distributes resources to assist health care providers with compliance with fraud and abuse laws. <About OIG, HHS OIG website>

IV. Web-Based Resources

   A. There are two main websites with Medicare source authority (i.e., Medicare "rules"):

1. The U.S. Government Printing Office (GPO) Federal Digital System (FDsys) website hosts statutes and regulations. The FDsys generally has prior versions of statutes and regulations going back several years.

2. The CMS website hosts CMS sub-regulatory guidance, including manuals, transmittals, and other guidance on the Medicare program.

> *Caution:* The CMS website does not maintain an archive of prior versions of manuals and often removes transmittals or other guidance without notice. If you rely on guidance from the CMS website, you should retain a printed or electronic copy to ensure you have it for future reference.

B. HCPro maintains a website with extensive links to Medicare resources, including the FDsys and CMS websites at:

https://www.revenuecycleadvisor.com/helpful-links

1. Handout 6 is a copy of HCPro's links page for your reference or to note links you find useful during class.

V. Key Sources of Authority

A. For your reference, Attachment A located behind the outline, is a table with key sources of authority, or Medicare "rules", as well as where they are published, where to find them on the internet, and example citations.

1. Attachment A is organized in the order audit contractors should apply guidance in making medical review decisions. <*Medicare Program Integrity Manual,* Chapter 3 § 3.3 A>

B. Statutes

1. Public Laws

a. Congress adopts new statutes as Public Laws. Public Laws are found on Congress.gov, maintained by the Library of Congress.

> *Link: Congress.gov under Regulations and Statutes*

b. Each public law has a home page that provides information on the adoption of the bill and the final text.

2. *United States Code* (*U.S.C.*)

> Tip: Under the "Text" tab, use the "Enrolled Bill" for an easy to use version of the text of a bill, with embedded links to related provisions.

a. The *U.S.C.* is a compilation of the statutes of the United States.

  i. Title 42 of the *U.S.C.*, which contains the Medicare laws, has not been enacted as positive law. Its text is prima facie evidence of the law, but the text of the Public Law, as enacted, takes precedence in the event of a conflict.

> **Link: Unites States Code (Federal Statutes) under Regulations and Statues**

3. Social Security Act

a. Frequently, Medicare laws are cited by their Social Security Act section number, rather than their *U.S.C.* section number. The Social Security Administration maintains an updated version of the Social Security Act.

> **Link: Social Security Act, Title 18 (Medicare) under Regulations and Statues**

C. Regulations

1. *Federal Register*

a. CMS publishes proposed and final regulations in the *Federal Register*.

> Regulations are first published as proposed rules with request for comment. After gathering comments, a final rule is published, which contains the final regulation and a preamble with significant commentary and responses to submitted comments.

b. On the Federal Register site, you can browse by date or use the "Search the Federal Register by citation" link on the left navigation area to search for a volume and page number.

> **Link: Federal Register under Regulations and Statutes**

  c. CMS also makes display copies of important proposed and final rules, along with accompanying data files and tables, available on their website.

> *Link: MPFS – Physician Fee Schedule Regulations and Notices under Medicare-Related Sites – Physician/Practitioner*

  d. Proposed and final rules can be very large and difficult to navigate.

    i. The "Summary of the Major Provisions" section in the "Executive Summary" at the beginning of the rule can be a helpful place to start.

> *Tip: Use the Table of Contents to find sections of interest and the "find" feature of the software to navigate to pertinent sections.*

    ii. Follow-up questions can be directed to the individuals in the "For Further Information Contact:" section.

> *Link: HHS Employee Directory under Medicare-Related Sites - General*

2. *Code of Federal Regulations (C.F.R.)*

  a. The *C.F.R.* is a compilation of the regulations of the United States. Title 42 contains the Medicare regulations.

    i. The *C.F.R.* is published in an official annual edition and a regularly updated electronic version referred to as the e*CFR*, an unofficial compilation of the *C.F.R.* and recent *Federal Register* amendments.

> *Caution: The annual edition of Title 42 is updated October 1 of each year, but some regulations (i.e., OPPS, MPFS) are adopted around November 1. Use the eCFR for the most up-to-date version of federal regulations.*

> *Link: CFR Title 42 – Electronic Version under Regulations and Statutes*

> *Tip: Use the Federal Register citations noted at the end of each regulation to find important preamble discussion published when the regulation or amendment was adopted.*

D. Sub-regulatory Guidance

1. Sub-regulatory guidance, such as manuals and transmittals, is not binding on Medicare contractors or Administrative Law Judges (ALJs). Regulations require they give "substantial deference" to the guidance applicable to a case and if they do not follow it, explain why in their decision letter. <42 *C.F.R.* 405.1062>

2. "Paper-based" Manuals

   a. The *Provider Reimbursement Manual* contains charging and cost reporting guidelines and is available in a "paper-based" version that can be downloaded from the CMS website.

   > *Link: Manuals – Paper Based Manuals under Medicare-Related Sites - General*

   b. The *Provider Reimbursement Manual* has two parts

      i. Part I provides cost report information such as Medicare's policies on "Bad Debts, Charity, and Courtesy Allowances" or the "Determination of Costs of Services", which provides information on the structure of charges.

      ii. Part II primarily provides cost report formats and completion instructions.

3. "Internet-only" Manuals (IOMs)

   a. CMS provides significant sub-regulatory guidance in "internet-only" manuals published directly on their website.

   > *Caution: CMS often removes or revises manual sections without providing an archive of prior versions. As noted above, you should retain a printed or electronic copy of manual sections you rely on to ensure you have them for future reference.*

   > *Link: Manuals – Internet Only Manuals under Medicare-Related Sites - General*

   b. The following IOMs may be particularly helpful:

      i. *Pub. 100-02 – Medicare Benefit Policy Manual* provides coverage requirements for various inpatient and outpatient services.

     ii. *Pub. 100-04 – Medicare Claims Processing Manual* provides coding, billing and claims guidance.

     iii. *Pub. 100-05 – Medicare Secondary Payer Manual* provides information related to Medicare as a primary or secondary payer.

     iv. *Pub. 100-07 – State Operations Manual* provides guidance on the Conditions of Participation.

> *Tip: To access detailed information, such as Tag numbers, Interpretive Guidelines, and Survey Procedures, open the "Appendices Table of Contents" and click on the "Appendix Letter" for the provider or survey type (e.g., "G" for "Rural Health Clinics" or "Z" for "Emergency Preparedness for All Providers and Certified Supplier Types).*

     v. *Pub. 100-08 – Medicare Program Integrity Manual* provides guidance to Medicare auditors, including MACs, SMRCs, CERT, Recovery Auditors, and ZPICs.

> *Tip: This manual is helpful to providers preparing for and responding to Medicare audits.*

4. Transmittals and Program Memoranda

    a. Transmittals communicate new or revised policies or procedures, as well as new, deleted or revised manual language.

> **Link: Transmittals and Program Memoranda under Medicare-Related Sites – General**
> *Use links on the left navigation to access transmittals or program memoranda from prior years.*

    b. Transmittal numbers

> *Format of transmittal numbers:*
>
> **R** (**Number** *– in the order of publishing*) (**Initials** *for manual*)
>
> *R10224CP: 224th published transmittal, Claims Processing Manual related*
>
> *Note: the numbering system for transmittals changed on approximately March 20, 2020. Previously, the transmittals were numbered separately for each manual, rather than by date across all manuals.*

Tip: One Time Notification (OTN) transmittals are global in nature and not tied to a specific manual

c. Change request numbers

   i. Transmittals are linked to a change request (CR) number, CMS' internal tracking number, tying together documents associated with a particular policy change.

   Change Request (CR) numbers:
   - *May be associated with multiple transmittals, e.g., one CR may have an associated Medicare Claims Processing Manual Transmittal and a Medicare Benefit Policy Manual Transmittal.*
   - *Are used in the numbering of associated MLN Matters Articles, discussed later in this outline.*
   - *Are often used by CMS representatives to refer to policy changes, rather than transmittal numbers.*

d. Components of a transmittal

   i. "Date" (in the header) represents the date the transmittal was published.

   ii. "Effective Date" represents the date of service the policy in the transmittal will begin to apply, unless noted otherwise.

   Caution: The effective date of a transmittal may be prior to the date the transmittal was published, which may affect coverage, coding, billing or payment of services already rendered.

   iii. "Implementation Date" represents the date processing systems will be able to process claims correctly according to the policies in the transmittal, unless noted otherwise.

   Caution: The implementation date of a transmittal is generally the first business day of the quarter or year after the transmittal is effective but may be substantially after the effective date. A provider may need to hold claims affected by the transmittal until system changes are implemented.

iv. If there are new, deleted, or revised manual sections associated with the transmittal, they will be listed in the "Changes in Manual Instructions" table at the beginning of the transmittal.

a) The text of new or revised manual sections will appear after the attachments at the end of the transmittal.

> **Caution:** *New or revised text will appear in red italics; however, deleted text will not be noted. Important guidance may be removed without any indication in the transmittal. Revisions should be reviewed carefully.*

v. "Background" and "Policy" sections provide important information about the policy changes in the transmittal.

vi. The "Business Requirements Table" contains specific instructions to CMS contractors for implementation of changes in the transmittal, including instructions related to reprocessing claims or adjusting claims brought to their attention by providers.

> *Tip: This section may be particularly helpful to providers to determine the effect of the transmittal on their claims.*

vii. The "Contacts" section contains the names and email addresses of CMS staff, which may be used for follow-up questions.

viii. Transmittals may also have attachments with important tables or other important information.

5. MLN Matters Articles

a. MLN Matters Articles are articles that explain Medicare policy in easy to understand format, often written for specific provider types as noted at the top of the article.

> *Link: MLN Matters Articles – Overview Page under Medicare-Related Sites – General*

b. There are two types of MLN Matters Articles:

i. MLN Matters Articles linked to a specific transmittal are intended to provide practical and operational information about the transmittal.

> *Tip: In addition to being published on the MLN website, a link for MLN Matters Article associated with a transmittal appears below the link for the transmittal on the transmittal's home page.*

ii. Special Edition MLN Matters Articles are not linked to a transmittal; however, they provide information on topics CMS believes require additional clarification and may contain information not found in transmittals or manuals.

> *Tip: In addition to appearing on the MLN website, Special Edition MLN Matters Articles are listed on the transmittals website for the year they were published.*

> *Format of MLN Matters Article numbers:*
>
> *Tied to a specific transmittal/change request:*
> **MM (Change Request Number)**
> *MM10417 is tied to CR10417*
> *Special Edition MLN:*
> **SE (two-digit year)(sequential number)**
> *SE18003 is the third Special Edition MLN Article in 2018*

6. Other Guidance

   a. CMS frequently posts other guidance on their website in the form of documents, FAQs, algorithms, or other information.

   b. Some helpful sites:

   > **Link: Rural Health Clinics Center under Medicare-Related Sites – Rural Health**

   > **Link: Critical Access Hospital Center under Medicare-Related Sites – Rural Health**

VI. Ways to Stay Current (All Free)

   A. Subscribe to HCPro's resources to receive information and updates applicable to your facility.

      1. Revenue Cycle Daily Advisor is a free daily email publication with informative articles gathered from a variety of HCPro and HealthLeaders sources.

      2. Revenue Integrity Insider is a free email publication with information from the National Association of Healthcare Revenue Integrity (NAHRI), an association dedicated to providing revenue integrity professionals with the resources, networking, and education needed to foster this growing field and profession.

> *Link: HCPro Free Email Newsletters under Listserv Subscriptions*

   B. Subscribe to CMS email updates.

> *Link: CMS Email Update Lists – Subscriber's Main Page under Listserv Subscriptions*

      1. Suggested CMS mailing lists include:

         a. CMS Coverage Email Updates

         b. MLN Connects™ Provider eNews

         c. CMS Open Door Forum Calls

            i. CMS conducts periodic "Open Door Forum" conference calls which provide valuable information for Medicare providers. You can receive dial in information by signing up to this list.

               a) The Rural Health Open Door Forum will include topics that mainly affect rural providers.

               b) The Physicians, Nurses, and Allied Health Professionals Open Door Forum will include topics that mainly affect physician and non-physician practitioner coding and billing.

> *Link: Open Door Forum – Overview page under Medicare-Related Sites – General*

         d. CMS News Releases (including proposed and final rule fact sheets)

         e. Subscribe to your MAC's email list.
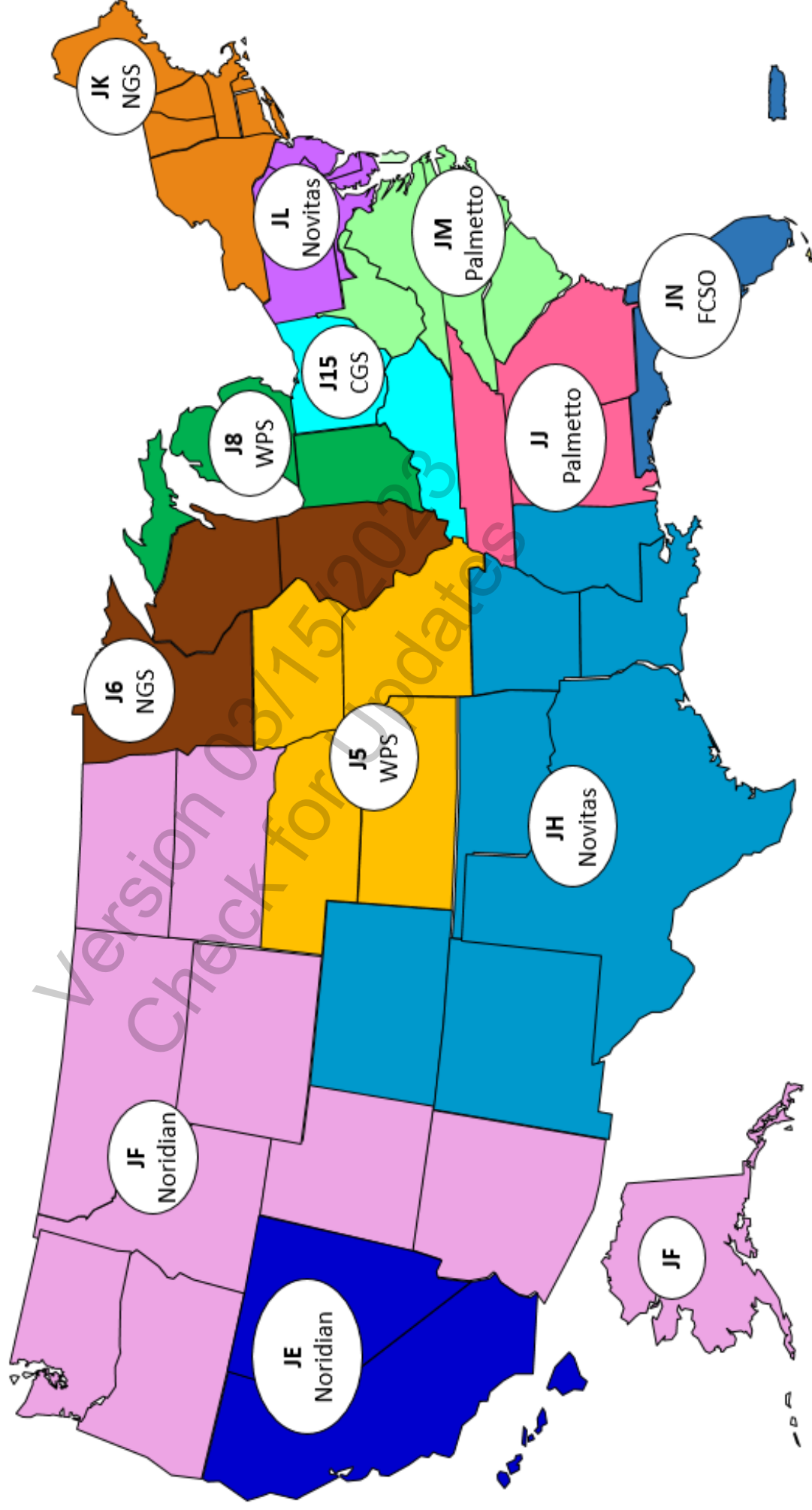
Medicare Rural Health Clinic Version

ATTACHMENT A
KEY SOURCES OF MEDICARE AUTHORITY

By	Authority	Published In	Example Citation	Location
Congress	Statutes	Public Laws	Bipartisan Budget Act of 2018, Pub. L. 115-123	Congress.gov
		United States Code	42 *U.S.C.* § 1395y	GPO's Federal Digital System (FDsys)
		Social Security Act	*SSA* § 1862	SSA website
CMS	Proposed and final Rules	*Federal Register*	81 *Fed. Reg.* 79562	GPO's FDsys CMS website
	Regulations	*Code of Federal Regulations*	42 *C.F.R.* § 491.3	GPO's FDsys
		Electronic *Code of Federal Regulations* (eCFR)		
	National coverage policies	National Coverage Determinations (NCD)	NCD 20.15 Electrocardiographic Services	CMS website
CMS	Sub-regulatory guidance	Manuals	*Medicare Claims Processing Manual*, Chapter 9 § 70.4	CMS website
		Transmittals	*Medicare Benefit Policy Manual Transmittal 230*	CMS website
		MLN Matters Articles	*MLN Matters SE1611*	CMS website
		Other guidance	*Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)*, (revised 10-14-16)	CMS website
MAC	Local coverage policies	Local Coverage Determinations (LCD) and Articles	LCD ID L36084, Article ID A54931	CMS website, MAC website

A/B MAC Jurisdictions
as of June 2021

JK
NGS

JL
Novitas

JM
Palmetto

JN
FCSO

J15
CGS

J8
WPS

JJ
Palmetto

J6
NGS

J5
WPS

JH
Novitas

JF
Noridian

JE
Noridian

JF

Version 03/15/2023
Check for Updates