J14 A/B MAC

PART B

Mental Health Services Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Mental Health Services billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-1, Chapter 3; Publication 100-2, Chapter 15; and Publication 100-4, Chapter 12 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at http://www.cms.gov/manuals/

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

Medicare Part B provides benefits for psychiatric services, which are medically necessary for the diagnosis or treatment of an illness or injury. Physicians, psychiatrists, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants are recognized by Medicare B to provide diagnostic and therapeutic treatment for mental, psychoneurotic and personality disorders. Independent Psychologists/Non-Clinical Psychologists are recognized by Medicare Part B for diagnostic services only. Coverage is limited to those services that the mental health professional is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses.

Provider Qualifications

Physicians - Psychiatrists

A physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice medicine in the State in which he/she performs services. The issuance by a State of a license to practice constitutes legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within those limitations are covered.

CONTRACTOR NOTE: The term physician does not include Christian Science practitioners.

Clinical Psychologist (CP)

To qualify as a Clinical Psychologist (CP), a CP must meet the following requirements:

- Hold a doctoral degree in psychology;
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Covered Services

CPs may provide the following services:

- Diagnostic and therapeutic services that a CP is legally authorized to perform in accordance with State law and/or regulation.
- Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services are met.
  - These services **must** be mental health services that are commonly furnished in CP's offices.
  - An integral, although incidental, part of professional services performed by the CP.
  - They **must** be performed under the direct personal supervision of the CP (the CP must be physically present and immediately available) and

- Furnished without charge or included in the CP bill.

Any person involved in performing the service must be an employee of the CP (or an employee of the legal entity that employs the supervising CP).
CONTRACTOR NOTE: "Incident-to" services will be addressed later in this Guide.

Noncovered Services
The services of CPs are not covered if the service is otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. Therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are **not** covered. CPs may **not** bill for pharmacological management.

Requirement for Consultation
When applying for a Medicare provider number, a CP must submit to the carrier a signed Medicare provider/ supplier enrollment form that indicates an agreement to the effect that, contingent upon the patient's consent, he or she will attempt to consult with the patient's attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality.

If the patient assents to the consultation, the CP must attempt to consult with the patient's physician within a reasonable time after receiving the consent. If the CP's attempts to consult directly with the physician are not successful, the CP must notify the physician within a reasonable time that he or she is furnishing services to the patient. Additionally, the CP must document, in the patient's medical record, the date the patient consented or declined consent to consultations, the date of consultation, or, if attempts to consult did not succeed, that date and manner of notification to the physician.

The only exception to the consultation requirement for CPs is in the cases where the patient's primary care or attending physician refers the patient to the CP. Neither a CP nor a primary care or attending physician may bill Medicare or the patient for this required consultation.

Independent Psychologist/Non-Clinical Psychologist (NCP)
To qualify as an Independent Psychologist/Non-Clinical Psychologist (NCP), a practitioner must meet the following requirements:

- Be licensed or certified to practice psychology in the State where the psychologist is furnishing the service
- Does not provide clinical services

Independent Psychologists/Non-Clinical Psychologists are only permitted by Medicare B to perform diagnostic psychological testing ordered by a physician.

Independent Practice
NHIC considers psychologists as practicing independently when:

- They render services on their own responsibility, free of the administrative and professional control of an employer, such as a physician, institution or agency;
- The persons they treat are their own patients; and
- They have the right to bill directly, collect and retain the fee for their services.

A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions are met:

- The office is confined to a separately-identified part of the facility, which is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and
- The psychologist conducts a private practice, i.e., services are rendered to patients from outside the institution as well as to institutional patients.

When the psychologist is practicing independently, he/she bills NHIC directly. However, if the psychologist is not practicing independently, but is on the staff of an institution, agency, or clinic, that entity bills for the diagnostic services.

Clinical Social Workers (CSW)
To qualify as a CSW, the following requirements must be met:

- Possess a master's or doctoral degree in social work;
- Have performed at least 2 years of supervised clinical social work; and either
- Be licensed or certified as a clinical social worker by the State in which the service(s) are performed; or
- In the case of an individual in a State that does not provide for licensure or certification, has completed at least 2 years or 3000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, skilled nursing facility (SNF) or clinic.

Coverage of Services
The services of a CSW may be covered under Medicare Part B if they are:

- The type of services that are otherwise covered if furnished by a physician, or as incident to a physician's service.
- Performed by a person who meets the definition of a CSW and
- Not otherwise excluded from coverage.

Non-covered Services
Services of a CSW are not covered by Medicare Part B when furnished to inpatients of a hospital, patients of a partial hospitalization program, or to inpatients of a skilled nursing facility (SNF) if the services furnished in the SNF are those that the SNF is required to furnish as a condition of participation with Medicare. In addition, CSW services are not covered if they are otherwise excluded from Medicare coverage even though a CSW is authorized by State law to perform them. Therapeutic services that are billed by a CSW under CPT psychotherapy codes that include E/M services are not covered. CSWs may not bill for pharmacological management. Also, there is no provision for billing services rendered incident to a CSW.

NOTE: Claims for outpatient LCSW services provided in a hospital, outpatient or other facility (except a nursing facility) must be submitted by the facility for payment. Claims rendered in place of service 21, 51, 52 or 61 are not covered by Medicare Part B.

NOTE: In Massachusetts the term LCSW refers to a Licensed *Certified* Social Worker and not a Licensed *Clinica*l Social Worker as defined above under Medicare requirements.

Physician Assistant (PA)
To qualify as a Physician Assistant (PA), a PA must meet the following requirements:

- Be a graduate of a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)); or
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the State to practice as a physician assistant.

Nurse Practitioner (NP)
To qualify as a Nurse Practitioner (NP), a NP who applied for Medicare billing numbers for the first time from January 1, 2001, through December 31, 2002 must meet the following requirements:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

NPs who apply for a Medicare billing number for the first time on or after January 1, 2003, must meet the following requirements:

- Be a registered professional nurse who is authorized by the State in which the services are

furnished to practice as a nurse practitioner in accordance with State law;
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
- Possess a master's degree in nursing.

Clinical Nurse Specialist (CNS)

To qualify as a Clinical Nurse Specialist (CNS), a CNS must meet the following requirements:

- Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;
- Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

INCIDENT-TO SERVICES

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services. For purposes of this section the term physician also means a practitioner including a physician assistant, nurse practitioner, clinical nurse specialist, and clinical psychologist. Incident-to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services must be performed under the physician's direct supervision. Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.

To be covered incident-to the services of a physician, services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics;
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

A PA, NP, CNS, and CP may provide services without direct supervision and have the service covered. However, a PA, NP, CNS, and CP may opt to provide services incident to a MD or DO. It is not within Medicare benefit categories for auxiliary personnel such as registered nurses or clinical professional counselors to provide services without direct supervision. Such auxiliary personnel may provide services incident to a PA, NP, CNS, or CP. The services will be covered if they would have been covered when furnished incident to the services of an MD or DO.

Auxiliary personnel is defined as any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

Where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident-to the physician's service if there is a physician's service rendered to which the services of such personnel are an integral, although incidental part and there is direct supervision by the physician.

CONTRACTOR NOTE: Services provided incident to a CSW cannot be billed by the CSW to the Medicare program.

CONTRACTOR NOTE: Pharmacological management services cannot be performed under the incident to provision.

MENTAL HEALTH SERVICES

Psychiatric Diagnostic Interview

A psychiatric diagnostic interview examination is the elicitation of a complete medical and psychiatric history (including past, family and social), completion of a comprehensive mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to work to solve the patient's mental problem.

An interactive medical psychiatric diagnostic interview is an initial evaluation typically furnished to children. This interview involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic action between the clinician and the patient who has not yet developed, or has lost, either the expressive language communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

90801 Psychiatric diagnostic interview examination
90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication

Psychiatric Therapeutic Procedures

Individual Psychotherapy is the treatment of psychiatric disorders in which a licensed psychotherapist communicates with an individual patient who has the capacity to understand and respond meaningfully. Through this therapeutic communication the clinician attempts to alleviate emotional disturbances, reverse, or change maladaptive patterns of behavior, and achieve optimal functioning.

Insight oriented, behavior modifying, and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change. Specific techniques include behavior modification,

supportive interactions, problem solving, cognitive restructuring, explanation of automatic thoughts, explanation of unconscious motivation, instruction in communication and socialization, and/or cognitive discussion of reality. Effective therapy results in improvement or maintenance of function.

Interactive psychotherapy is typically furnished to children. It uses physical aides such as play equipment, language interpreter, or other mechanisms for nonverbal communication to achieve therapeutic interaction. These patients do not have the language skills necessary to explain symptoms and behaviors. Adults may have receptive or expressive deficits for ordinary language due to mild mental retardation, aphasia, dysarthria, or language barriers.

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy, the place of service, the face to face time spent with the patient during psychotherapy and whether evaluation and management services are furnished on the same date of service as psychotherapy.

Office or Other Outpatient Facility

90804-90809 Insight oriented, behavior modifying and or supportive psychotherapy

90810-90815 Interactive Psychotherapy

Appropriate Place of Service Codes

Office or other outpatient facility (90804-90815)
03 School
04 Homeless Shelter
11 Office
12 Patient's Home
14 Group Home
20 Urgent Care
22 Outpatient Hospital
23 Emergency Room - Hospital
49 Independent Clinic
53 Community Mental Health Center
62 Comprehensive Outpatient Rehabilitation Facility (CORF)

E/M and Psychotherapy Rendered on the Same Day

Evaluation and Management (E/M) services are not separately payable when provided by the same provider on the same day as covered individual psychotherapy. Providers should submit the individual psychotherapy CPT code that includes the E/M service that is provided to a patient on the same day as a psychotherapy session.

The following psychotherapy codes contain an E/M component: 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827 and 90829.

NOTE: Medicare does not pay CPs and CSWs for CPT codes that include an E/M component.

Family Medical Psychotherapy

Family medical psychotherapy (without the patient present) can be considered based on medical documentation submitted with the claim. This service involves family participation in the treatment process of the patient.

Indications of coverage

Family medical psychotherapy is considered reasonable and necessary when at least **one** of the following two indications is present:

- To promote family understanding of the patient's condition and to provide discussion of the patient's progress toward specific goals or
- To promote understanding of the patient's plan of care and/or condition where the patient is withdrawn and uncommunicative due to a mental disorder or comatose status, **and**
- Meets the definition of family*

  *Family representative is defined as immediate family members (only husband, wife, siblings, children, grandchildren, grandparents, mother, father are included), primary caregiver who provides care on a voluntary, uncompensated, regular, sustained basis, guardian, or health care proxy.

90846 Family Psychotherapy (without the patient present)
90847 Family Psychotherapy (with the patient present)
90849 Multiple-family group psychotherapy

CONTRACTOR NOTE: Family Medical Psychotherapy is neither a treatment for the relatives, nor treatment for an individual family member's problem.

CONTRACTOR NOTE: Multiple Family Group psychotherapy has restricted coverage. Documentation must be submitted.

Group Psychotherapy

Group psychotherapy is a form of treatment in which a carefully selected group of patients are guided by a licensed psychotherapist for the purpose of helping to effect changes in maladaptive patterns which interfere with social functioning and are associated with a diagnosable psychiatric illness.

90853 Group psychotherapy (other than of a multiple-family group)
90857 Interactive group psychotherapy

CONTRACTOR NOTE: Group psychotherapy must document the actual number of participants at each session.

CONTRACTOR NOTE: More than one group therapy code billed on the same date of service by the same provider is not allowed although one individual and one group therapy billed on the same date of service by the same provider can be paid if reasonable and necessary for the condition of the patient and fully documented in the patient's records.

Psychoanalysis

Psychoanalysis is a method of obtaining a detailed account of past and present mental and emotional experiences and repressions, in order to determine the source and eliminate the pathologic mental or physical state produced by these mechanisms. Psychoanalysis is a covered service when reasonable and necessary.

90845 Psychoanalysis

Pharmacologic Management

Psychiatric pharmacologic management involves the management of medication by a clinician, licensed to prescribe, including prescription, use, and review of medication with no more than minimal psychotherapy. The patient must have a psychiatric or central nervous system illness, or demonstrate emotional or behavioral symptoms affecting functional status. The primary focus of the visit is the management of psychotropic drugs, including monitoring for withdrawal syndrome or worsening of the psychiatric condition.

90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders

NOTE: Psychiatric Pharmacology is not payable on the same day when psychotherapy with an evaluation & management component is performed.

Electroconvulsive Therapy

Electroconvulsive therapy is the application of electric current to the brain for up to several seconds through scalp electrodes to induce a single seizure to produce a therapeutic effect. Separate payment of anesthesia is allowed when performed by someone other than the psychiatrist, otherwise it is included in the payment for electroconvulsive therapy.

90870 Electroconvulsive therapy (includes necessary monitoring); single seizure

If reported as a separate service, the allowance for psychotherapy will be denied as included in the allowance for the same day electroconvulsive therapy.

Central Nervous System Assessments/Tests

Psychological and neuropsychological testing is a diagnostic service. The allowance for testing includes test administration, scoring, interpretation, diagnostic formulation, and written report. Testing by a psychologist is eligible for reimbursement in the inpatient and outpatient setting when performed to determine the emotional and behavioral characteristics of an individual in order to obtain an objective measure of the person's intelligence and personality. It is also considered for reimbursement for senile and pre-senile organic psychotic conditions. Supervision of diagnostic psychological and neuropsychological testing is required. Physicians and Clinical Psychologists may perform this general supervision. Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants that personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision of a Physician or Clinical Psychologist.

96101 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or the physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

96102 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face

96103 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report per hour.

96110 Developmental testing, limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.

96111 Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) per hour of psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

Neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain injury through testing of the neuro-cognitive domains responsible for language, perception, memory, learning, problem solving, adaptation, and constructional praxis.

These tests are carried out on patients who have suffered neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. They are objective and quantitative in nature and require patients to directly demonstrate their level of competence in a particular cognitive domain. They are not a substitution for clinical interviews, medical or neurologic examinations, or other diagnostic procedures used to diagnose neuropathology. Rather, when used judiciously in patients with particular neuropsychological problems, they can be an important tool in making specific diagnoses or prognoses after neurologic injury, to aid in treatment planning, and to address questions regarding treatment goals, efficacy, and patient disposition.

96118 Neuropsychological testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test) per hour of the psychologist's or the physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

96119 Neuropsychological testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test) with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face

96120 Neuropsychological testing (e.g. Wisconsin Card Sorting Test) administered by a computer, with qualified health care professional interpretation and report

CONTRACTOR NOTE: CPT codes from 96102, 96103, 96119 and 96120 include tests performed by technicians and computers in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners.

Health and Behavior Assessment/Intervention

Health and Behavior Assessment procedures are used to *identify* the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of *physical* health problems. The focus is *not on mental health*, but on the biopsychosocial factors important to physical health problems and treatments.

Health and Behavior Intervention procedures are used to *modify* the psychological, behavioral, emotional, cognitive and social factors identified as important to or directly affecting the patient's *physiological* functioning, disease status, health, and well-being. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient: initial assessment

96151 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires) each 15

minutes face-to-face with the patient; re-assessment

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)

96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with patient present)

CONTRACTOR NOTE: 96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present) is a non-covered service.

CONTRACTOR NOTE: Medicare coverage of Behavior Health codes is limited to Clinical Psychologists only.

Hypnotherapy

Medicare will consider Hypnotherapy if reasonable and necessary for the treatment of a medical or psychological condition.

90880 Hypnotherapy

Narcosynthesis

Narcosynthesis is a type of therapy directed toward making the patient recall repressed memories and emotional traumas requiring the patient to be under the influence of a hypnotic drug such as a barbiturate. This is a covered service with the Medicare program when based on medical necessity.

90865 Narcosynthesis for psychiatric diagnosis and therapeutic purposes (e.g., sodium amobarbital (amytal) interview)

Biofeedback Therapy

Biofeedback therapy is covered under Medicare **only** when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is **not covered** for treatment of ordinary muscle tension or for psychosomatic conditions.

90901 Biofeedback training for any modality

90911 Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

NON-COVERED SERVICES

Environmental Intervention

90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions. Environmental intervention services are **not covered.**

Geriatric Day Care Programs

Geriatric or adult day care programs **are not covered** as they are not considered reasonable and necessary for a diagnosed psychiatric disorder. These non-covered services include:

- Social and recreational activities for individuals who require general supervision during the day;
- Psychosocial programs for social interaction;
- Vocational training for employment opportunities, work skills, or work settings;
- Family counseling.

CONTRACTOR NOTE: There may be occasions when a medical or psychotherapeutic service is rendered in a geriatric or adult day care setting. Services rendered in these facilities are reported with Place of Service 11 if the professional maintains office space within the day care facility.

Individual Psychophysiological Therapy Incorporating Biofeedback Training by any Modality

90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes.

90876 Approximately 45-50 minutes

These services are **non-covered**.

Marriage Counseling

Medicare **does not** recognize marriage counseling as a payable service.

Preparation of Reports

90889 Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

This service is bundled. No separate payment can be allowed. The beneficiary **cannot** be billed. Separate payment for preparation of reports of the patient's psychiatric status, history, treatment, or progress for other physicians, agencies or insurance carriers is **not available** under the Medicare program. Documentation of services and test results rendered is required by all providers. Reimbursement is bundled into the Medicare payment that is made for services

rendered by the health care professional.

Interpretation/Explanation of Results or Data

90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist the patient.

This service is bundled. No separate payment can be allowed. The beneficiary **cannot** be billed. Separate payment for the interpretation and communication of data and test results to the patient, family members or legal guardian is not available. Reimbursement is bundled into the Medicare payment that is made for services rendered by the health care professional.

Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes

90885 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

This service is bundled. No separate payment can be allowed. The beneficiary **cannot** be billed. Reimbursement is bundled into the Medicare payment that is made for services rendered by the health care professional.

Telephone Services

99441-99443

This service is bundled. **No separate** payment can be allowed and the beneficiary **cannot** be billed.

When these services are performed, payment for them is inclusive in the payment for the services to which they are incident. For example: a telephone call from a hospital nurse is received regarding care of a patient. This service is not paid separately as it is included in the payment for other services such as a hospital visit.

REIMBURSEMENT

Methods of Payment (Assigned vs. Non-assigned)

The **assigned** method of payment indicates the provider/supplier rendering services to a Medicare beneficiary agrees to accept the Medicare *allowance* as payment in full and will receive direct payment from NHIC for services billed. Providers agree to accept assignment for all services rendered to Medicare patients.

The **nonassigned** method states the provider will receive payment from the beneficiary and Medicare will reimburse the beneficiary. The provider may not collect from the Medicare beneficiary any amount in excess of the **Limiting Charge** for service(s) rendered. See the Medicare Fee Schedule at: www.medicarenhic.com

NOTE: State billing laws affect the amount providers can charge Medicare beneficiaries. In some states, the laws apply only to beneficiaries who meet certain means tests. However, in other states, the provisions apply to all beneficiaries. These laws may limit providers charging no more than the Medicare approved amount on all claims, or on unassigned claims, to charging no more than a small percentage above the approved amount. If you practice in a state with balance billing laws, you should obtain more precise information from the state agency administering those laws. Currently, Vermont and Massachusetts have balance billing laws.

CMS requires that the following providers must accept assignment:

CP	Clinical Psychologist
CSW	Clinical Social Worker
PA	Physician Assistant
NP	Nurse Practitioner
CNS	Clinical Nurse Specialist

Reimbursement Rate

The physician fee schedule is reviewed and revised annually. It is published on the NHIC website at www.medicarenhic.com on the Fee Schedule page.

- The fee schedule for a physician and a psychologist is 100% of the physician fee schedule or actual charge, whichever is less
- The fee schedule for a PA, NP and CNS is 85% of the physician fee schedule or actual charge, whichever is less
- The fee schedule for a CSW is 75% of the physician fee schedule or actual charge, whichever is less
- The fee schedule amount is then reduced by any applicable deductible, outpatient mental

health treatment limitation and co-insurance

Outpatient Mental Health Treatment Limitation

Section 102 of MIPPA requires that the current 62.5% outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

January 1, 2010 – December 31, 2011, the limitation percentage is 68.75% (of which Medicare pays 55% and the patient pays 45%);

January 1, 2012 – December 31, 2012, the limitation percentage is 75% (of which Medicare pays 60% and the patient pays 40%);

January 1, 2013 – December 31, 2013, the limitation percentage is 81.25% (of which Medicare pays 65% and the patient pays 35%); and,

January 1, 2014 – onward, the limitation percentage is 100%, at which time Medicare pays 80% and the patient pays 20%.

Services provided in outpatient settings are subject to the limitation. The limitation applies to claims for professional services that represent mental health treatment furnished to individuals, who are not hospital inpatients, by physicians, clinical psychologists, clinical social workers, and other allied health professionals. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation.

The limitation applies only to treatment services. It does not apply to diagnostic services. The following is a listing of services **not** subject to the limitation:

1. Diagnosis of Alzheimer's Disease or Related Disorder - When the primary diagnosis reported for a particular service is Alzheimer's Disease, the nature of the service that has been rendered is looked at in determining whether it is subject to the limitation. Typically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the limitation. However, when the primary treatment rendered to a patient with such a diagnosis is psychotherapy, it is subject to the limitation.

2. Brief Office Visits for Monitoring or Changing Drug Prescriptions - Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders are not subject to the limitation. These visits are reported using HCPCS code M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders).

3. Diagnostic Services – The limitation does not apply to tests and evaluations performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric or psychological tests and interpretations, diagnostic consultations, and initial evaluations.

   An initial visit to a practitioner for professional services often combines diagnostic evaluation and the start of therapy. Such a visit is neither solely diagnostic nor solely therapeutic. The initial visit is deemed to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible, unless the practitioner already has separately identified them. Determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made and certainly before therapy can be instituted. Moreover, the patient should not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit.

4. Partial Hospitalization Services Not Directly Provided by Physician - The limitation does not apply to partial hospitalization services that are not directly provided by a physician. These services are billed by hospitals and community mental health centers (CMHCs) to intermediaries.

The following facilities are considered "inpatient" and are not subject to the outpatient limitation:

Inpatient
21 Inpatient Hospital
51 Inpatient Psychiatric Facility
61 Comprehensive Inpatient Rehabilitation Facility

Calculating the Mental Health Treatment Limitation

The limitation reduces the established fee schedule amount by 68.75% in 2010 for **each** outpatient service received by the beneficiary. The beneficiary is responsible for the difference between the approved amount and the reduced amount in addition to the 20% co-insurance amount. If the patient has not satisfied their annual Medicare deductible, that amount is deducted from the approved amount after the 68.75% calculation. An example of the limitation follows.

Without Deductible

Provider Billed Charge:	$100.00
Approved Amount/ Fee Schedule Amount	$ 66.50
68.75% of $66.50 (Approved Amount)	
Adjusted/Reduced Medicare Allowance	$ 45.72
Patient responsibility **(PR)** difference Between $66.50 and $45.72	$20.78 **(PR)**

NOTE: *Medicare then calculates the 80% payment with the adjusted approved amount*

80% of Reduced Medicare Allowance $45.72 x 80% = Medicare payment	$36.58
20% Patients Coinsurance $45.72 X 20%	$9.14 **(PR)**
Total Medicare Payment to Provider	**$36.58**
Total Patient Responsibility (PR) ($20.78 plus $9.14)	**$29.92 (PR)**

With Deductible

Provider Billed Charge:	$100.00
Approved Amount/ Fee Schedule Amount	$ 66.50
68.75% of $66.50 (Approved Amount)	
Adjusted/Reduced Medicare Allowance	$ 45.72
Patient responsibility **(PR)** difference Between $66.50 and $45.72	$ 20.78 **(PR)**

NOTE: *Medicare first applies the deductible then calculates the 80% payment with the adjusted approved amount.*

Deductible	$ 20.00 **(PR)**
80% of Reduced Medicare Allowance $45.72-$20.00=$25.72 x 80% = Medicare payment	$ 20.58
20% Patients Coinsurance $25.72 X 20%	$ 5.14 **(PR)**
Total Medicare Payment to Provider	**$ 20.58**
Total Patient Responsibility (PR) ($20.78 plus $20.00 plus $5.14)	**$ 45.92 (PR)**

BILLING AND CODING GUIDELINES

Documentation of the Medical Record for Mental Health Claims

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of services include the following:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history;
  - Physical examination findings and prior diagnostic test results;
  - Assessment, clinical impression, and diagnosis;
  - Plan for care; and
  - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported on the health insurance claim should be supported by documentation in the medical record.

NOTE: Individual psychotherapy can be billed as one of three time periods: 20 to 30 minutes, 45 to 50 minutes, or 75 to 80 minutes. Because reimbursement of psychotherapy services is based on **face-to-face** time spent with the patient, practitioners are required to document in the medical record the time duration (stated in minutes) spent in the psychotherapy encounter with the patient. One of the principal causes of miscoded services occurs because no time is documented. When this happens, the services should

be billed at the lowest possible time period. Although CPT codes include time in the narrative, it is imperative to include time in the patient's medical record. Practitioners should refer to the psychotherapy Local Coverage Determination (LCD) posted on our Web site for complete documentation requirements.

Excluded Information Per Privacy Rule

Psychotherapy notes differ from regular medical records and receive special protection from other medical records that may be exchanged between providers and insurance companies without special beneficiary permission. Psychotherapy notes are defined under the privacy rule as:

"Notes recorded (in any medium) by a mental health professional which document or analyze the contents of conversation during a counseling session **and** that are separated from the rest of the individual's medical record."

The definition of psychotherapy notes expressly excludes the following:

- Medication prescription and monitoring
- Session start and stop times
- Modalities and frequencies of treatment
- Clinical test results
- Summary of
    - Diagnosis
    - Functional status
    - Treatment plan
    - Symptoms
    - Prognosis
    - Progress to date

If a provider does not keep excluded information separate from the psychological notes, then the provider would need to extract the information not protected under the privacy guidelines from the patient's records and submit it to the carrier upon request to support the reasonableness and necessity of the claim. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

Documentation of Evaluation and Management Services

CMS established medical record documentation guidelines for evaluation and management services in 1995 and 1997. These guidelines are available on the American Medical Association bulletin board, the CMS website or may be obtained by contacting Customer Service. All

evaluation and management services provided to a patient should be documented, regardless of whether the evaluation was performed as an independent service or in conjunction with other services rendered during a patient encounter.

Psychologists and clinical social workers are restricted from using evaluation and management services and the psychiatric codes with an E/M component.

Claim Submission

Complete instructions for completion of the paper CMS-1500 claim form are provided in the Claim Form CMS- 1500 instructions guide. Copies of this guide are available through Customer Service or at **www.medicarenhic.com** in the Publications section of the website. Electronic claims may be filed for mental health services. The same information is reported regardless of the method of submission. Electronic claims are recognized as being more efficient, have faster processing times, and result in faster payment of Medicare claims to providers.

Procedure Coding

The Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) is the coding system used by Medicare B nationwide and consists of two levels of codes and modifiers used by Medicare. Level I contains the American Medical Association's (AMA) CPT codes which are numeric. Level II contains alpha-numeric codes primarily for items and non-physician services not included in CPT. Level II codes are maintained jointly by CMS, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America.

Services provided to Medicare beneficiaries must be reported using the appropriate CPT or HCPCS code. It is not appropriate to report medical Evaluation and Management (E/M) procedure codes when psychotherapy is the reason for the encounter. If the medical E/M is the only service rendered on a given date of service, the appropriate E/M procedure code should be used.

Modifiers

Modifiers are used with both CPT and HCPCS procedure codes to provide additional information relative to the service or procedure being submitted for reimbursement. Modifiers often have a direct impact on reimbursement. **Failure to use the appropriate modifier may result in incorrect payment**. The following modifiers are available for use when psychotherapy services are reported to Medicare.

Modifier	Definition
AH	Indicates that the therapeutic service(s) reported was **personally performed** by a clinical psychologist being billed by a group or clinic.
AJ	Indicates that a therapeutic service(s) reported was **personally performed**

by a CSW being billed by a group or clinic.

59	Indicates that a therapeutic service was distinct or independent from other services performed on the same day. The 59 identifies services that are not normally performed together. May represent different session, patient encounter, procedure, or surgery.

Units of Service

Mental health services are typically reported as one unit per session. Providers should choose the most appropriate mental health time-based code that reflects the actual service length provided. Indicate the number of days or units that are being provided on that date of service.

Diagnosis Code Requirements

Report appropriate ICD-9-CM diagnosis codes in item 21 and reference the code in item 24E of the CMS-1500 claim form or the electronic equivalent. The diagnosis code(s) chosen should accurately describe the patient's illness, disease, signs or symptoms.

Codes must be used to their highest level of specificity (e.g. 3, 4 or 5 digits) Follow instructions provided in the ICD-9-CM to avoid return or denial of claims for incorrect or invalid diagnosis coding. Diagnosis codes considered acceptable for mental health billing are: 290-319 and 331.0.

CONTRACTOR NOTE: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is not the HIPAA standard for diagnosis coding. Although the DSM-IV includes diagnostic guidelines unlike the ICD9, make sure you have the most current edition of the ICD-9 code book, which is updated on an annual basis, to avoid claim rejects and denials.

Reference Books

HCPCS, *CPT* and *ICD-9-CM* references may be purchased in local bookstores or by writing or calling the following:
Practice Management Information Corporation (PMIC)
4727 Wilshire Boulevard, Ste. 300
Los Angeles, CA 90010
1-800-633-7467 www.pmiconline.com

American Medical Association
P.O. Box 10946
Chicago, IL 60610-0946
1-800-621-8335

US Government Printing Office
Superintendent of Documents
Washington, DC 20402
1-866-512-1800 www.gpo.gov

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: **http://www.cms.gov/NationalCorrectCodInitEd/**

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: **http://www.cms.gov/BNI/**

ABN Modifiers

GA Waiver of liability statement issued, as required by payer policy
GX Notice of liability issued, voluntary under payer policy
GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: **http://www.cms.gov/mcd/search.asp**

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: ***1-800-HHS-TIPS (1-800-447-8477).*** Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversied Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on http://www.dcsrac.com/

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on http://www.cms.gov/CERT/

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:
8:00 a.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 4:00 p.m. - Friday
866-801-5304

Dedicated Reopening Requests Only
Hours of Operation:
8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday
877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission	
Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:
www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp. **Provider Service Line:** 1-866-419-9458

Please view the website to find the appropriate address:
http://www.medicarenhic.com/dme/contacts.shtml

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

http://www.medicarenhic.com

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:
http://visitor.constantcontact.com/email.jsp?m=1101180493704

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links
From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

http://www.cms.gov/center/coverage.asp
http://www.cms.gov/mcd/indexes.asp

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

http://www.cms.gov/MLNGenInfo/

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

http://www.cms.gov/OpenDoorForums/

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

http://www.cms.gov/CMSForms/

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)	**http://cms.gov/BNI/**
American Medical Association	**http://www.ama-assn.org/**
CMS	**http://www.cms.gov** **http://www.medicare.gov**
CMS Correct Coding Initiative	**http://www.cms.gov/NationalCorrectCodInitEd/**
CMS Physician's Information Resource for Medicare	**http://www.cms.gov/center/physician.asp?**
Electronic Prescribing	**http://www.cms.gov/erxincentive/**

Evaluation and Management Documentation Guidelines
http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register	http://www.archives.gov/federal-register http://www.gpoaccess.gov/index.html
HIPAA	http://www.cms.gov/HIPAAGenInfo/
National Provider Identifier (NPI)	http://www.cms.gov/NationalProvIdentStand/

NPI Registry
https://nppes.cms.gov/NPPES/NPIRegistryHome.do

Physicians Quality Reporting	http://www.cms.gov/pqri/

Provider Enrollment, Chain, and Ownership System (PECOS)
http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment
http://www.cms.gov/MedicareProviderSupEnroll/

U.S. Government Printing Office	http://www.gpoaccess.gov/index.html

Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Sue Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal

NHIC, Corp.

75 Sgt. William Terry Drive
Hingham, MA 02044

Website:
http://www.medicarenhic.com

CMS Websites
http://www.cms.gov
http://www.medicare.gov