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Acute Care Hospitals: Preparing Inpatient Claims – The Basics Part 1

4/17/2025

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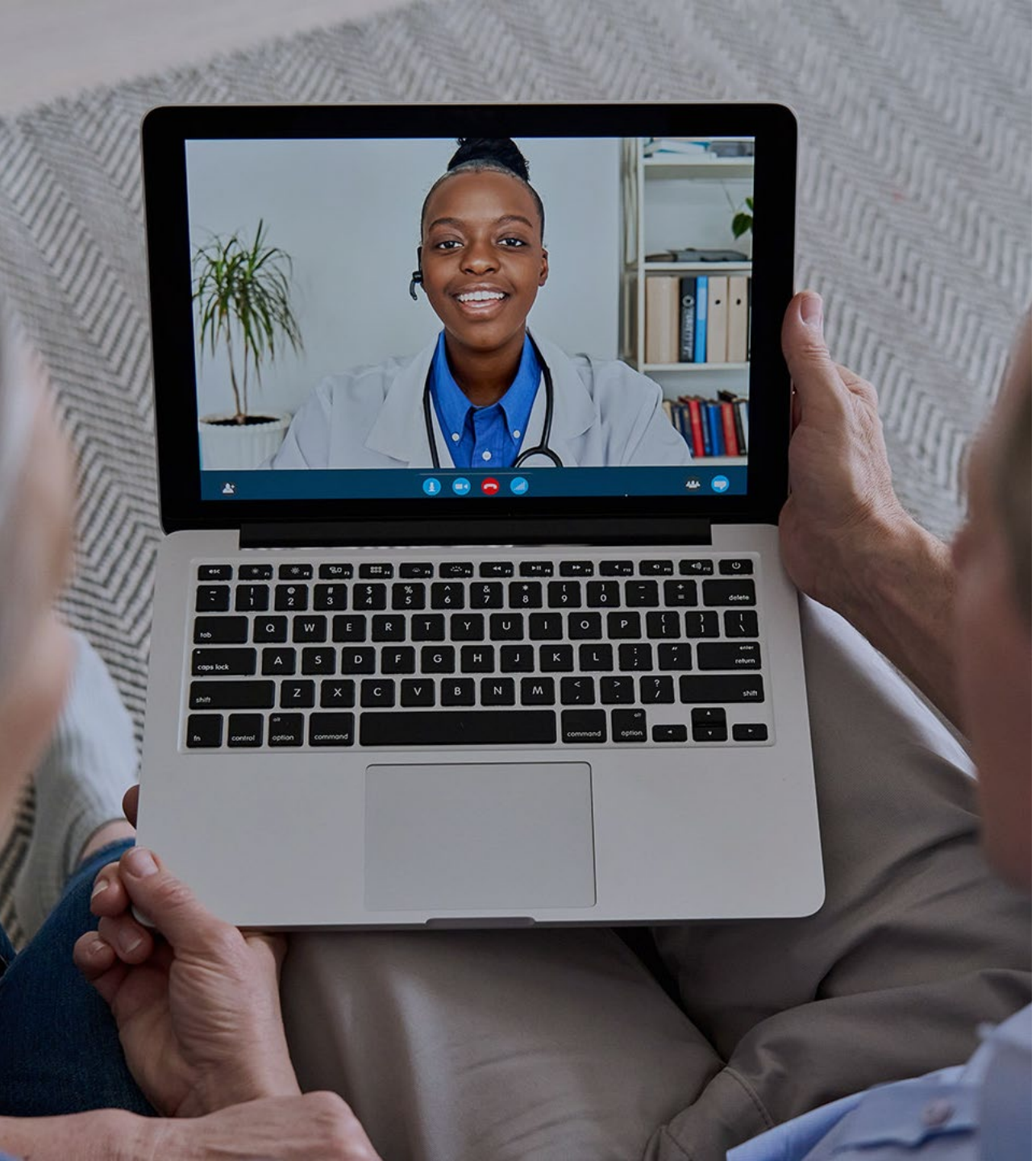

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Objective

Assist ACHs in understanding how to prepare and submit compliant claims to Medicare so fewer of your claims RTP for billing errors

Today's Presenters

- Provider Outreach and Education Consultants
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

- General IP ACH Information
- Preparing Claims For Submission to Medicare
- FL Review
- References and Resources
- Questions

General IP Hospital Information

Medicare Part A

- Referred to as “Hospital Insurance”
- Covers IP stays
- Five major benefits
  - **IP hospital services**
  - IP SNF care
  - Skilled services by HHA
  - Hospice care
  - Blood transfusions

IP Hospital Coverage Conditions

- Hospital must
  - Have signed provider agreement with Medicare to be participating hospital
- Beneficiary must
  - Be enrolled in Medicare Part A
  - Have Medicare IP hospital benefit days available in benefit period
  - Receive reasonable/necessary care that can only be provided in IP hospital

IP Hospital Coverage Conditions (continued)

- Physician must
  - Formally admit beneficiary as IP via IP order
    - Per CFR Title 42 Chapter IV Section 412.3
  - Expect he/she will remain at least overnight even if beneficiary discharged/transferred and does not use a bed overnight
- CMS two-midnight rule references:
  - CMS Fact Sheet About Two-Midnight Rule
  - CR10080, Clarifying Medical Review of Hospital Claims for Part A Payment

Tip – Verify Beneficiary Has Medicare Part A

- Hospital staff must
  - Collect insurance information and cards from beneficiary
  - Determine if beneficiary has Medicare (or MAO plan)
    - Medicare's records (FISS DDE/CWF, HETS, and/or NGSConnex)
  - Determine if beneficiary has coverage primary to Medicare
    - MSP screening process
    - Determine proper order of insurance per MSP Provisions

IP Benefit Days Under Medicare Part A per Benefit Period

- Per benefit period, beneficiary receives
  - 100 IP SNF benefit days
    - 20 full days and 80 coinsurance days (renewable)
  - Up to 150 IP hospital benefit days
    - 90 regular days (renewable)
      - First 60 days = full days; deductible applies
      - Next 30 days = coinsurance days; daily coinsurance applies
    - 60 LTR days (not renewable)
      - Daily coinsurance applies

IP Hospital LTR Days

- Beneficiary
  - Can elect not to use LTR days
  - May be responsible for cost of stay past regular benefit days
- Provider
  - Must inform beneficiary of right not to use LTR days
- Reference:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 5

Medicare Beneficiary Responsibility

- Beneficiary's IP hospital liability limited to:
  - Deductible
    - 2025 = $1,676
  - Regular day coinsurance (days 61-90)
    - 2025 = $419 per day
  - LTR day coinsurance (days 91-150)
    - 2025 = $838 per day
  - Services not reasonable and medically necessary (beneficiary liable services only)
  - Statutorily excluded services

Medicare Benefit Period

- Tracks beneficiary's use of IP benefit days
  - IP hospital and SNF benefit days used separately but linked to same benefit period
    - Begins when beneficiary admitted as IP to qualified hospital or SNF after Medicare Part A entitlement date
    - Ends 60 consecutive days from date of beneficiary's last IP discharge
      - Beneficiary not IP in hospital or receiving IP skilled care in SNF for 60 days in a row
- Reference:
  - CMS IOM Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3

Benefit Period Facts

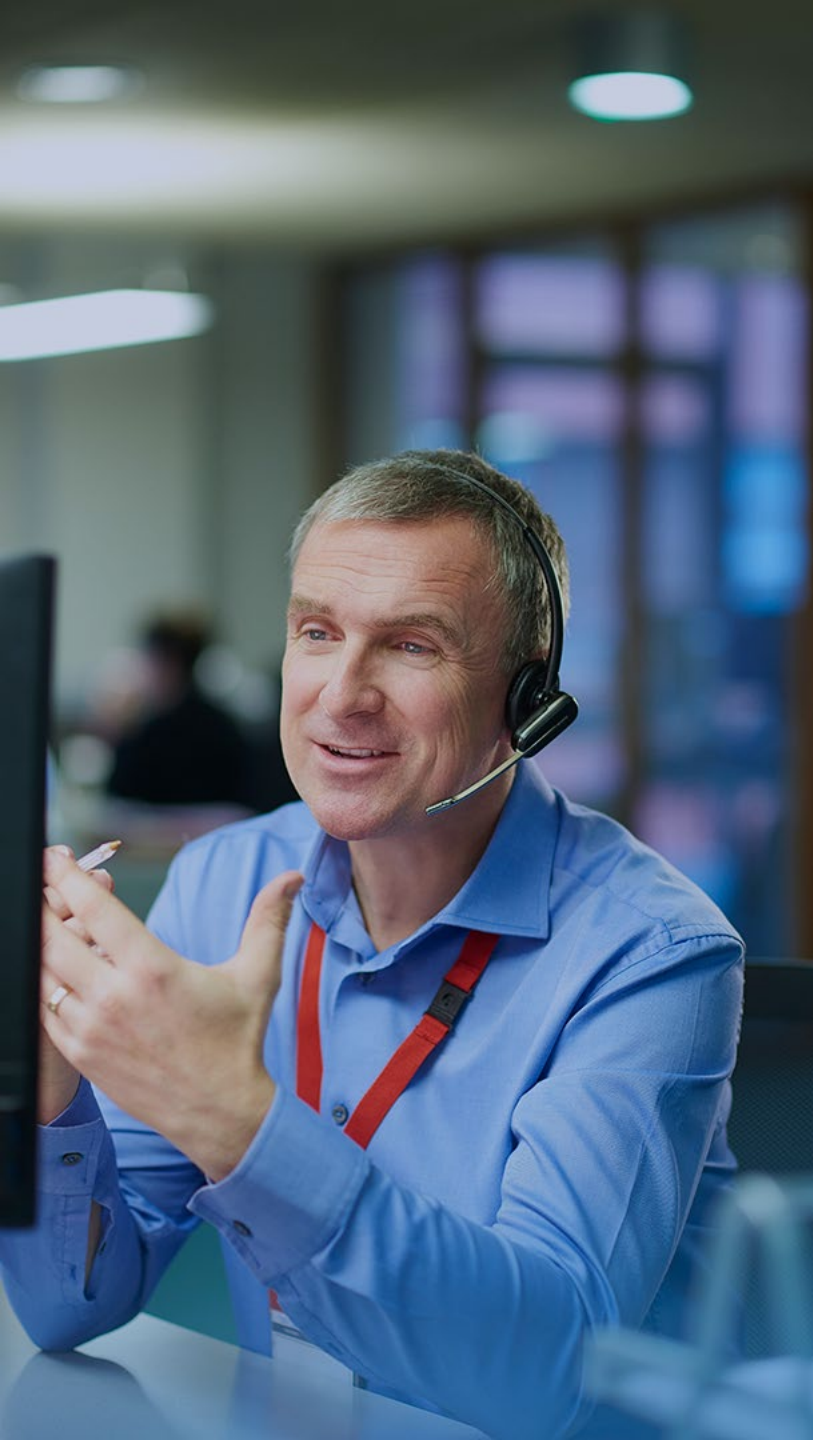
- A benefit period
  - Does not begin when beneficiary has a new illness/injury
  - Does not end if beneficiary admitted as IP to a hospital or SNF prior to 60th consecutive day from last IP discharge
    - Beneficiary continues to use any remaining IP benefit days available
  - Is not bound by a calendar year
    - Can last for years if beneficiary not facility-free for 60 consecutive days or does not have a 60 consecutive-day break in skilled care (from SNF)

Benefit Period Examples

- Who gets a new benefit period?
  - It is 4/17/2025 and you work at ABC Hospital
  - Three beneficiaries waiting to be admitted
  - Determine if each eligible for a new benefit period
  - Review recent IP summaries for each beneficiary on next slide

Does Beneficiary Get a New Benefit Period When Admitted on 4/17/2025?

- Mrs. A
  - IP hospital stay 1/3/2025 – 1/10/2025
  - Not IP in any other hospital or SNF since 1/10/2025
    - Yes; more than 60 days passed from 1/10/2025 to 4/17/2025
- Mr. B
  - IP hospital stay 3/14/2025 – 3/23/2025
  - Not IP in any other hospital or SNF since 3/23/2025
    - No; less than 60 days passed from 3/23/2025 to 4/17/2025
- Mrs. C
  - IP hospital stay 12/28/2024 – 1/2/2025
  - Transferred to SNF on 1/2/2025 (covered); discharged home on 2/25/2025
  - Not in any other hospital or SNF since 2/25/2025
    - No; less than 60 days passed from 2/25/2025 to 4/17/2025



Tip – Verify Benefit Period and IP Hospital Benefit Days Available

- Determine if beneficiary was IP in hospital or SNF (skilled LOC) within past 60 days
  - If yes, he/she in a current benefit period
    - Determine IP hospital benefit days used and remaining
    - Obtain name/address of provider(s)
  - If no, he/she not in a current benefit period
    - This IP admission starts new benefit period

IP Hospital Services

- Covered services – treat patient's illness/injury
  - Room and board
    - Semiprivate room
    - Private room under certain conditions
  - Ancillary services
    - Drugs/medications
    - Laboratory, X-ray and radiology services

General Exclusions from Medicare

- Include but are not limited to
  - Services not R&N
  - Custodial care
  - Certain dental services
  - Routine foot care
  - Cosmetic surgery
- References:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
  - MLN® Booklet: *Items and Services Not Covered Under Medicare*

IP Hospital Discharge Planning

- Hospitals must
  - Have discharge planning process for all patients
  - Include discharge planning evaluation in patient's medical records
    - Must include evaluation of patient needing post-hospital services and availability of services
  - Discuss results of evaluation with patient or individual acting on his/her behalf

IP Beneficiary Notices

- Provide appropriate HINN to beneficiary if you determine items/services not covered
  - Provide
    - Prior to admission
    - At admission
    - At any point during IP stay
  - Not covered
    - Not reasonable and medically necessary
    - Not delivered in most appropriate setting or
    - Custodial in nature
- Beneficiary Notices Initiative (BNI)

IP Beneficiary Notices (continued 1)

- HINNs
  - HINN 1: Preadmission/Admission HINN – entirely noncovered stay
  - HINN 10: Notice of Hospital Requested Review (HRR) – used when hospital requests Beneficiary and Family Centered Care (BFCC)-QIO review of a discharge decision without physician concurrence
  - HINN 11: Used for noncovered services during otherwise covered stay
  - HINN 12: Used in association with Hospital Discharge Appeal Notice to inform beneficiary of potential financial liability for noncovered continued IP stay

IP Beneficiary Notices (continued 2)

- FFS & MA IM – additional information on Important Message from Medicare (IM) and Detailed Notice of Discharge (DND)
  - IM
    - Beneficiary notice issued within two days of IP admission to explain rights as a patient
    - Follow-up copy provided up to two days, and no later than four hours, before IP discharge
  - DND
    - Issued to IP who requests expedited review of discharge to explain specific reason for discharge

IP Beneficiary Notices (continued 3)

- Medicare Change of Status Notice (CMS-10868)
  - Effective 10/11/2024 and implemented 2/15/2025
  - Hospitals providing IP level of care must issue to beneficiaries formally admitted as IP but reclassified to OP receiving observation services
    - Deliver to those eligible for expedited determination process while still IP to notify them of their right to appeal reclassification with BFCC-QIO
      - Deliver as soon as possible, but no later than four hours prior to discharge
  - Reference:
    - MLN Matters® MM13846 *"Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services)"*

IP Hospital Claims Are Subject to Review

- Medical review
  - Targeted Probe and Educate
- Entities contracted with CMS
  - Comprehensive Error Rate Testing (CERT)
  - Quality Improvement Organizations
  - Medicare Fee for Service Recovery Audit Program
  - Supplemental Medical Review Contractor

Medicare Reimbursement for IP Hospital Services

- Made under IPPS
- Based on MS-DRGs
- Subject to IP hospital deductible and coinsurance
- References:
  - Acute Inpatient PPS
  - Inpatient PPS Web Pricer

Preparing Claims for Submission to Medicare

Billing Instructions

- Complete claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Inpatient Hospital Billing

Claim Resources

- Claim form
  - UB-04/CMS-1450, 837I claim or claim entry via FISS DDE
  - MLN® Booklet *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- FLs
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
    - FL 1 to FL 81 names and descriptions but no codes
    - FLs may be required or situational
- Codes
  - NUBC members access billing codes from NUBC's UB-04 Data Specifications Manual

Prior to Submitting Claims to Medicare

- Check with internal departments to ensure all services reported on claim
- Verify all required data elements entered accurately and completely
- Check if a claim already submitted
- Consider our one-year timely filing requirement
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

Submitting Claims to Medicare

- UB-04/CMS-1450 hardcopy claim form
  - Must have approved ASCA waiver
  - ASCA Requirements for Paper Claim Submission
- Via FISS DDE or through clearinghouse
- Using 837I electronic claim form
  - EDI and How it Works

Claims Status/Locations in FISS

- When claim submitted for processing, it receives a S/L
  - Basic S/Ls include:
    - P B9997 – Claim processed
    - S XXXXX – Claim suspended
    - R B9997 – Claim rejected
    - T B9997 – Claim RTP
    - D B9997 – Claim denied

Claim Status and Provider Action

- If claim RTP (S/L = T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
    - Select PF9 to resubmit claim
- If claim rejected (S/L = R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim denied (S/L = D B9997)
  - Determine if appeal needed
  - Documentation must support services rendered

FL Review

Assumptions for Presentation

- You determined Medicare primary payer
  - No other primary payers involved
    - Not reviewing MSP-related claim FLs or codes
- You understand how to code required claim information for
  - Provider identification
  - Patient identification

Claim FLs for Provider Identification

- FL 1 = Billing provider name, address, telephone number
- FL 5 = Federal tax number
- FL 56 = Billing provider NPI
- FL 76 = Attending provider name and identifiers
- FL 77 = Operating provider name and identifiers
- FLs 78 and 79 = Other provider name and identifiers

Claim FLs for Patient Identification

- FL 3a = Patient control number
- FL 3b = Medical/health record number (situational)
- FL 8 = Patient's name and identifier
- FL 9 = Patient's address
- FL 10 = Patient's birth date
- FL 11 = Patient's sex
- FL 50a = Payer (Medicare if Medicare primary)
- FL 58a = Insured's name (beneficiary if Medicare primary)
- FL 59a = Patient's relationship to insured (self if Medicare primary)
- FL 60a = Insured's Unique ID (certificate/social security number/**MBI**)

Other Claim FLs

- FL 4 = TOB
- FL 6 = Statement covers period (from and through dates)
- FL 12 = Date of admission
- FL 14 = Priority (type) of admission
- FL 15 = Point of origin for admission
- FL 17 = PSC as of statement covers period through date (FL 6)
- FLs 18-28 = CCs
- FLs 31-34 = OCs and dates
- FLs 35-36 = OSCs with from/through dates
- FLs 39-41 = VCs and amounts
- FL 42 = Revenue code

Other Claim FLs (continued)

- FL 44 = HCPCS/Rates/HIPPS Rate codes (accommodation rate)
- FL 46 = Unit(s) of service
- FL 47 = Total charges (not needed for electronic billing)
- FL 48 = Noncovered charges
- FL 64 = DCN
- FL 67 = Principal diagnosis code
- FLs 67 A-Q = Other diagnosis codes
- FL 69 = Admitting diagnosis code
- FL 74 = Principal procedure code and date
- FLs 74 A-E = Other procedure codes and dates
- FL 80 = Remarks

FL 4 – TOB

- Required
  - Four-digit alphanumeric code
    - First digit = zero (ignored)
    - Second digit = type of facility
    - Third digit = type of care
    - Fourth digit = sequence of bill in episode of care; frequency code
- IP claim submissions = one claim per stay
  - Submit through final discharge/death even if IP hospital benefit days exhaust or care becomes noncovered

TOBs for IP Claims

- "One claim per stay" concept
  - TOBs
    - 111 = Admission to discharge claim
    - 112 = First interim claim
    - 117 = Subsequent interim claim and adjustment claim
    - 118 = Cancel claim
    - 110 = No-payment claim
    - 12X = IP ancillary claim

FL 6 – Statement Covers Period

- Required
  - Beginning and ending dates of period on bill (MMDDYY)
    - From date = earliest DOS (consider payment window)
    - Through date = ending of claim
- Tip: Total number of days in statement covered period = covered days + noncovered days
  - If not equal, we RTP claim with reason code 12206
    - If beneficiary discharged/transferred, through date not included
    - If beneficiary still a patient (PSC = 30), through date included

FL 12 – Admission/Start of Care Date (Required)

- Date beneficiary formally admitted as an IP for IP care
- Format: MMDDYY

FL 14 – Priority (Type) of Admission (Required)

- Options:
  - 1 = Emergency
  - 2 = Urgent
  - 3 = Elective
  - 4 = Newborn
  - 5 = Trauma center
  - 9 = Not available

FL 15 – Point of Origin for Admission (Required)

- Code indicating source of referral for admission:
  - 1 = Non-health care facility
  - 2 = Clinic or physician's office
  - 4 = Transfer from hospital (different facility)
  - 5 = Transfer from SNF, assisted living, ICF or other nursing facility
  - 6 = Transfer from another health care facility
  - 8 = Court/law enforcement
  - 9 = Information not available
  - D = Transfer from distinct unit of hospital to another of same hospital resulting in separate claim to payer
  - E = Transfer from ASC
  - F = Transfer from a hospice facility
  - G = Transfer from a designated disaster alternate care site

FL 17 – Patient Discharge Status (Required; Known as PSC)

- As of “through” date of billing period (FL 6)
  - Two-digit codes that can affect payment (e.g.; transfers)
  - Select carefully and report accurately
  - What do your internal records indicate?
  - What is receiving facility’s provider type?
  - Does your ACH plan to readmit beneficiary as IP? (Use options 81-95)
  - Be prepared to change it if we cancel or RTP claim with reason code C7272, resubmit claim with correct code

PSCs

- 07 = Left against medical advice or discontinued care
- 09 = Admitted as an IP to this hospital
- 20 = Patient expired
- 30 = Still a patient
- Discharged/transferred to:
  - 01 = Home or self-care (if readmission planned = 81)
  - 02 = Short-term general hospital as IP (if readmission planned = 82)
  - 03 = SNF for covered skilled care (if readmission planned = 83
  - 04 = ICF (if readmission planned = 84)
  - 05 = Cancer or children's hospital (if readmission planned = 85)

PSCs (continued)

- Discharged/transferred to:
  - 06 = Home for covered home health care (if readmission planned = 86)
  - 21 = Court/law enforcement (if readmission planned = 87)
  - 43 = Federal health care facility (VA hospital) (if readmission planned = 88)
  - 50 = Hospice (home)
  - 51 = Hospice (medical facility)
  - 61 = Swing bed (if readmission planned = 89)
  - 62 = IRF (if readmission planned = 90)
  - 63 = LTCH (if readmission planned = 91)
  - 64 = Nursing facility (Medicaid) (if readmission planned = 92)
  - 65 = IPF (if readmission planned = 93)
  - 66 = CAH (if readmission planned = 94)
  - 70 = Another type of health care institution (if readmission planned = 95)

FLs 18 to 28 – CCs (Situational)

- Two-digit code describing certain conditions or events
  - Common IP CCs (not an all-inclusive list):
    - 04 = Informational-only claim
    - 07 = Hospice patient services not related to terminal illness
    - 40 = Same-day transfer
    - 66 = Hospital does not wish to receive HCO
    - 67 = Beneficiary elects not to use LTR days
    - 69 = IME, DGME & N&AH only
    - B4 = Admission unrelated to discharge on same day

CCs for Adjustment Claims

- D0 = Change to service dates
- D1 = Change to charges
- D2 = Change in revenue codes/HCPCS/HIPPS rate code
- D3 = Second or subsequent interim PPS bill
- D4 = Change in clinical codes (ICD) for diagnosis and/or procedure codes, Grouper PRICER input (DRG) IP hospital
- D7 = Change to make Medicare secondary
- D8 = Change to make Medicare primary
- D9 = Any other change (state reason in Remarks)
- E0 = Change in patient status

CCs for Cancel Claims

- D5 = Incorrect MBI/incorrect provider number
- D6 = Duplicate/overpayment (do not use for MSP reasons)

FLs 31 to 34 – OCs and Dates (Situational)

- Two-digit code for certain events or occurrences and date in MMDDYY format
  - Common IP OCs (not an all-inclusive list):
    - 31 and date of written notice to patient – not at covered LOC
    - 32 and date of written notice to patient – service/treatment not covered
    - 47 and date on which claim exceeded HCO threshold
    - 55 and date of death
    - A3 and benefits exhaust date

FLs 35 To 36 – OSCs and Dates (Situational)

- Two-digit code for certain events related to services
  - Associated from and through dates in MMDDYY format
    - Common IP OSCs (not an all-inclusive list):
      - 70 and nonutilization dates (inlier); applied by Medicare
      - 72 and number of midnights before IP admission (continuous OP hospital services that preceded IP admission)
      - 74 and noncovered LOC/LOA dates
      - 76 and patient liability dates

FLs 39 To 41 – Value Codes and Dollar or Unit Amounts (Situational)

- Two-digit code and dollar or unit amount (number)
  - Up to nine numeric digits (0000000.00)
  - Four lines of data, line A through line D
    - Use FLs 39A through 41A before 39B through 41B
  - Common VCs include (not an all-inclusive list):
    - 31 = Patient liability amount
    - 80 = Covered days
    - 81 = Noncovered days
    - 82 = Coinsurance days
    - 83 = LTR days

FL 42 – Revenue Codes (Required)

- Revenue codes for services provided to patient directly or under arrangement:
  - Accommodations (010X–012X)
  - Ancillary charges (022X–099X)
  - Alternative therapy services (210X)
  - Add total charges line (0001)
- Tip: We RTP claims with reason code 32242 if submitted with noncovered revenue codes

FL 44 – HCPCS/Rates/HIPPS Rate Codes (Required)

- Accommodations rate for each accommodation revenue code on claim
  - When reporting revenue code 0636, report valid HCPCS code
    - Drugs requiring detailed coding, including hemophilia clotting factors

FL 46 – Units of Charges (Required)

- Units of service for each revenue code on claim
- Quantifies services provided
  - For accommodations, units must = number of days
    - If not, we RTP claim with reason code 15202
  - When HCPCS codes required
    - Units = number of times procedure/service performed

FLs 47 and 48 (Required)

- FL 47 – Total Charges
  - Not applicable for electronic billers
  - Sum of charges for each revenue code on claim
    - Place total of all charges next to revenue code 0001
  - Tip: If covered day count = 0 but total covered charges > 0, we RTP claim with reason code 31090
- FL 48 – Noncovered Charges
  - Sum of noncovered charges, if any, for each revenue code
    - Place total of all noncovered charges next to revenue code 0001

FL 64 – DCN (Situational)

- For adjustments (TOB 117) and cancels (TOB 118)
  - Report control number assigned to original claim by health plan or health plan's fiscal agent as part of their internal control

FL 67 – Principal Diagnosis Code and Present on Admission Indicator (Required)

- ICD-10-CM code for principal diagnosis
- Also known as primary diagnosis code
  - Condition established after study to be chiefly responsible for this admission, even if another diagnosis may be more severe
- References:
  - CMS Hospital-Acquired Conditions (Present on Admission Indicator)
  - CMS POA Indicator Options and Definitions

POA Indicators – IP Claims

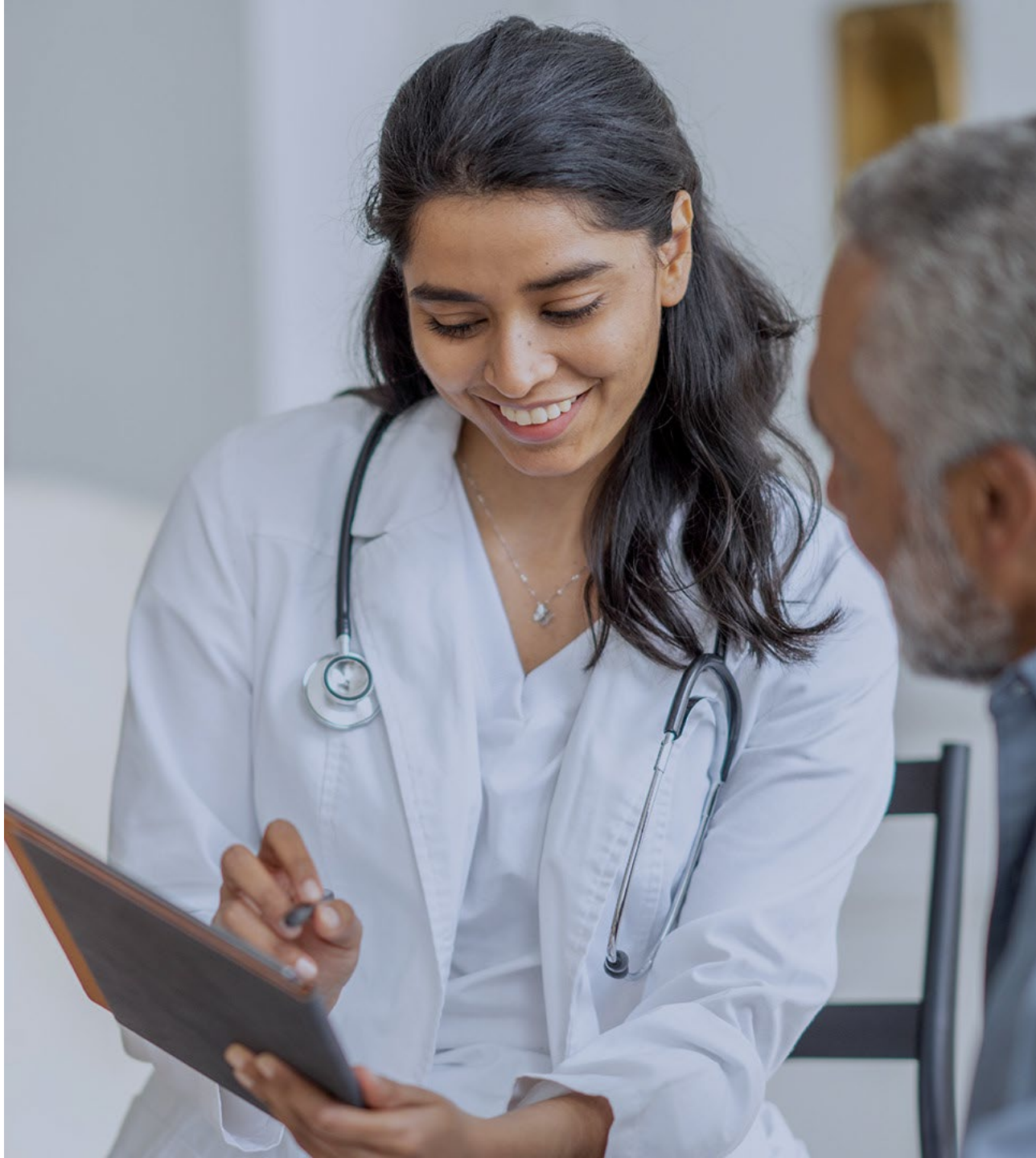
- ACHs must submit with each diagnosis code
  - POA – present at time order for IP admission occurs
  - Conditions that develop during OP encounter considered
  - Codes Y, N, U, W or blank when exempt from reporting
- Reason codes 34929, 34931, and 34031 indicate errors in POA
- Reference:
  - Hospital Acquired Conditions and Present on Admission Resource for Acute Care Hospital Facilities

FLs 67A to 67Q – Other Diagnosis Codes (Situational)

- ICD-10-CM codes for up to eight more conditions if they
  - Coexist at time of admission or developed subsequently
  - Had effect upon treatment or LOS
  - Do not duplicate principal diagnosis
- Reference:
  - CMS ICD-10

FL 69 – Admitting Diagnosis (Required)

- ICD-10-CM code for admitting diagnosis
- Condition identified by physician at admission requiring hospitalization



FL 74 and FLs 74A Through 74E – Procedures/Dates (Situational)

- FL 74
  - ICD-10-PCS Principal procedure code/date
  - Required when procedure was performed
- FLs 74A-74E
  - Other ICD-10-PCS procedure codes/dates
  - Required when additional procedures were performed
- Reference:
  - CMS ICD-10

FLs 80 and 81 (Situational)

- FL 80 – Remarks
  - Special annotations
  - Information not shown elsewhere on bill but needed for payment
  - Certain MSP situations
  - Certain RTP situations
- FL 81 – Code-Code Field
  - Additional codes related to a FL

What You Should Do Now

- Review references and resources
- Share information with staff
- Follow instructions for submitting IP ACH claims
- Develop and implement policies that ensure claims correctly submitted to Medicare
- Attend future education for ACHs

References and Resources

National Government Services

- Acronym Search Tool
- ASCA Requirements for Paper Claim Submission
- Contact Us
  - NGSConnex, IVR, Mailing Addresses and PCC
- EDI and How it Works
- *FISS DDE Provider Online Guide*
- NGSConnex
- Top Claim Errors

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- Acute Care Hospital Inpatient Prospective Payment System
- Acute Inpatient PPS
- Beneficiary Notices Initiative (BNI)
- CERT Task Force Article: Patient Discharge Status Codes Matter
- CMS ICD-10 Official Coding Guidelines for 2025
- CMS IOM Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 5
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16

CMS (continued 1)

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Sections 50.2.1 and 70
  - Chapter 3, Inpatient Hospital Billing
  - Chapter 25, Section 75
- Comprehensive Error Rate Testing (CERT)
- CR6801 Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List
- CR10080, Clarifying Medical Review of Hospital Claims for Part A Payment
- CR13846, Billing Instructions Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)

CMS (continued 2)

- Fact Sheet About Two-Midnight Rule
- FFS & MA IM
- HETS
- Hospital-Issued Notice of Noncoverage (HINN)
- Hospital-Acquired Conditions (Present on Admission Indicator)
- ICD-10
- Inpatient PPS Web Pricer
- Medicare Change of Status Notice (CMS-10868)
- Medicare Fee for Service Recovery Audit Program
- MLN® Booklet: *Items and Services Not Covered Under Medicare*
- MLN® Booklet: *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- MLN Connects® Newsletters

CMS (continued 3)

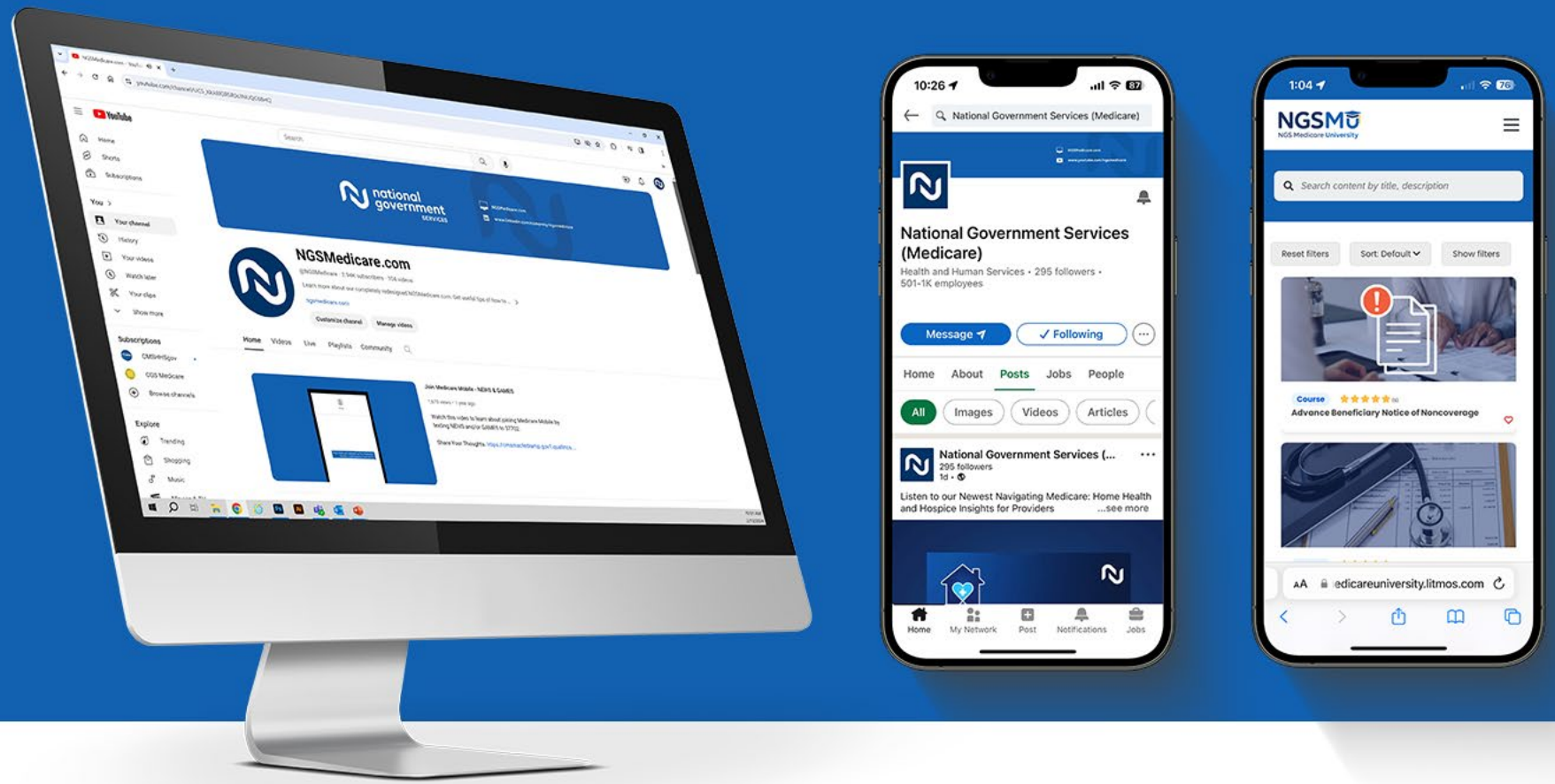
- MLN Matters® Articles
- MLN Matters® *MM13846: Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services*
- MLN® Web-Based Training
- MSP Provisions
- Open Door Forums
- POA Indicator Options and Definitions
- Quality Improvement Organizations
- Supplemental Medical Review Contractor
- Targeted Probe and Educate
- Transmittals/CRs

Other

- CFR Title 42 Chapter IV Section 412.3
- NUBC Website

Questions?

Thank you!



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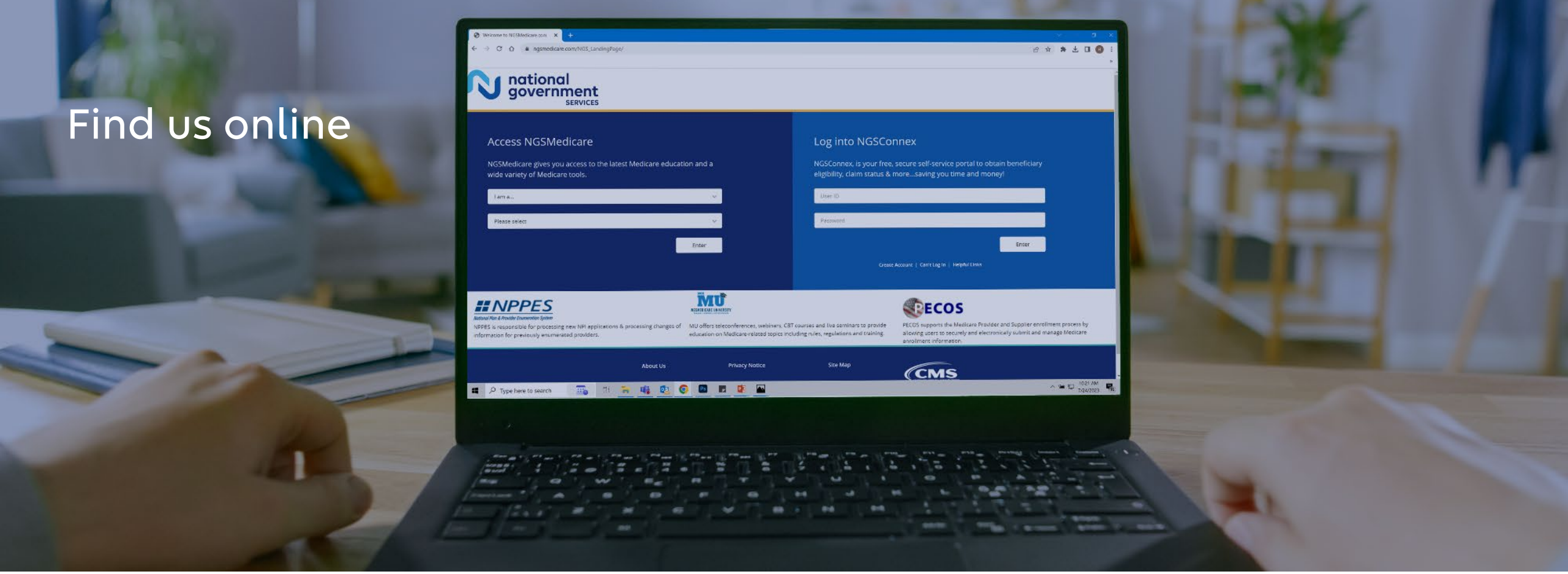

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