CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1335	**Date: SEPTEMBER 14, 2007**
	Change Request 5708

This transmittal is corrected to delete " or NPI when required" from IOM Chapter1, Section 30.3.12.1.J, (a)1.A, in the Field column of item 6. All other material remains the same.

Subject: Updating the Internet Only Manual (IOM) to Include Language "or NPI When Required"

I. SUMMARY OF CHANGES: This CR updates the Internet Only Manual (IOM) to include the language "or NPI when required ".

New / Revised Material
Effective Date: May 23, 2007 The effective date applies to claims received on or after this date.
Implementation Date: October 1, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/30.2.10/Payment Under Reciprocal Billing Arrangements-Claims Submitted to Carriers
R	1/30.2.11/Physicians Payment Under Locum Tenens Arrangements- Claims Submitted to Carriers
R	1/30.2.13/Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims
R	1/30.3.12.1/Carrier Participation and Billing Limitations

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1335	Date: September 14, 2007	Change Request: 5708

SUBJECT: Updating the Internet Only (IOM) Manual to Include the Language "or NPI When Required."

This transmittal is corrected to delete " or NPI when required" from IOM Chapter1, Section 30.3.12.1.J, (a)1.A, in the Field column of item 6. All other material remains the same.

Effective Date: May 23, 2007. The effective date applies to claims received on or after this date.

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: The National Provider Identifier (NPI) final rule, published on January 23, 2004, established the standard for a unique identifier for each health care provider for use in health care transactions. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. Covered entities may invoke contingency plans after May 23, 2007, and guidance about contingency plans have been published in various change requests.

B. Policy: This instruction updates the manual to include the language "or NPI when required", in various places in Chapter 1 of the Medicare Claims Processing manual. The NPI was scheduled to be required to be used by all providers on and after May 23, 2007. However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. Per Change Request 5607, Transmittal 1238, issued May 11, 2007, the legacy number will NOT be accepted on any inbound or issued on any outbound transaction, with exception to VA claims and placeholder NPIs after May 23, 2008.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5708.1	Contractors shall be in compliance with the updated manual instructions in Pub. 100-04, Section 30.2.10	X			X							
5708.2	Contractors shall be in compliance with the updated manual instructions in Pub. 100-04, Section 30.2.11	X			X							
5708.3	Contractors shall be in compliance with the updated manual instructions in Pub. 100-04, Section 30.2.13	X			X							
5708.4	Contractors shall be in compliance with the updated manual instructions in Pub. 100-4, Chapter	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	1, Section 30.3.12.1.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None											

IV. SUPPORTING INFORMATION N/A

X-Ref Requirement Number	Recommendations or other supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Melvia Page-Lasowski, CMS, 410-786-4727, Melvia.pagelasowski@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC);***
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****;**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers

(Rev.1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

The patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis, if:

- The regular physician is unavailable to provide the visit services;
- The Medicare patient has arranged or seeks to receive the visit services from the regular physician;
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days; and
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS code Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering the unique physician identification number (UPIN) or NPI when required on the form and cross-referring the entry to the appropriate service line item(s) by number(s). Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The term "**covered visit service"** includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as incident to the physician's services.

"Incident to" services furnished by staff of a substitute physician or regular physician are covered if furnished under the supervision of each.

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician provides covered visit services to Medicare Part B patients of the regular physician, and ends with the last day the substitute physician provides services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

EXAMPLE: The regular physician goes on vacation on June 30, and returns to work on September 4. A substitute physician provides services to Medicare Part B patients of the regular

physician on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive direct payment for them. The substitute physician must bill for these services in his/her own name. The regular physician may, however, bill and receive payment for the services that the substitute physician provides on his/her behalf in the period July 2 through August 30.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

A. Physician Medical Group Claims Under Reciprocal Billing Arrangements

The requirements of this section generally do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified in the manner described in §30.2.13 with one exception. When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5 modifier may be used **by the designated attending physician** to bill for services related to a hospice patient's terminal illness that were performed by another group member.

For a medical group to submit assigned and unassigned claims for the covered visit services of a substitute physician who is **not** a member of the group and for an independent physician to submit assigned and unassigned claims for the substitution services of a physician who **is** a member of a medical group, the following requirements must be met:

- The regular physician is unavailable to provide the visit services;
- The Medicare patient has arranged or seeks to receive the visit services from the regular physician; and
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days.

Substitute billing services are billed for each entity as follows:

- The medical group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q5 after the procedure code.
- The independent physician must enter in item 24 of Form CMS-1500 HCPCS code modifier Q5 after the procedure code.
- The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q5 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.
- A record of each service provided by the substitute physician must be kept on file and associated with the substitute physician's UPIN or NPI when required. This record must be made available to the carrier upon request.
- In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required in block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are treated as independent physicians for purposes of applying the requirements of this section.

Carriers should inform physicians of the compliance requirements when billing for services of a substitute physician. The physician notification should state that, in entering the Q5 modifier, the regular physician (or the medical group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician identified in a record of the regular physician which is available for inspection, and are services for which the regular physician (or group) is entitled to submit the claim. Carriers should include in the notice that penalty for false certifications may be civil or criminal penalties for fraud. The physician's right to receive payment or to submit claims or accept any assignments may be revoked. The revocation procedures are set forth in §40.

If a line item includes the code Q5 certification, carriers assume that the claim meets the requirements of this section in the absence of evidence to the contrary. Carriers need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the certifications by a particular physician may not be valid.

When carriers make Part B payment under this section, they determine the payment amount as though the regular physician provided the services. The identification of the substitute physician is primarily for purposes of providing an audit trail to verify that the services were furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician.

30.2.11 - Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers

(Rev.1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

A. Background

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee. These substitute physicians are generally called "locum tenens" physicians.

Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. Thus, beginning January 1, 1995, a regular physician may bill for the services of a locum tenens physicians. A regular physician is the physician that is normally scheduled to see a patient. Thus, a regular physician may include physician specialists (such as a cardiologist, oncologist, urologist, etc.).

B. Payment Procedure

A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a

locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- The regular physician is unavailable to provide the visit services;
- The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days; and
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a locum tenens physician) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) or NPI when required to the carrier upon request.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

C. Medical Group Claims Under Locum Tenens Arrangements

For a medical group to submit assigned and unassigned claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements of subsection B must be met. For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the locum tenens physician is considered paid by the regular physician. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 60 days. The group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q6 after the procedure code. Until further notice, the group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required on block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the requirements of subsection A for payment for locum tenens physician services. Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term "regular physician" includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev.1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses Form CMS-1500 or the current ANSI X12N billing format to submit claims to Medicare carriers. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ANSI X12N location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For EDI claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

The entity's NPI, when required, is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24J for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

C Payment Records

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, carriers transmit the performing physician's UPIN or NPI when required on the Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

D Outpatient Physical Therapy or Speech-Language Pathology Claims

Clinics that have been certified to provide outpatient physical therapy or speech-language pathology services to outpatients also use Form CMS-1500 for billing the Part B carrier.

30.3.12.1 - Carrier Participation and Billing Limitations

(Rev.1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

A. Participation Period

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin on November 15 of each year. Carriers will receive the participation enrollment material under separate cover.

NOTE: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the Final Rule.

B. Participation Enrollment and Fee Disclosure Process

The CMS will furnish carriers, via a separate instruction, with the participation materials used for the annual participation open enrollment period. Carriers mail the annual participation materials on a CD-ROM. Carriers must place the new fees and the anesthesia conversion factor(s) on their web site after the final rule is placed on display. Carriers shall not include the new fees on the CD-ROM. CMS has decided not to place the fees on the CD-ROM in order to have greater flexibility for making any last minute changes to the payment rate. Placing the fees on the carriers Web sites assures that providers will have the most current and correct fees available. The CMS transmits the MPFSDB electronically to carriers each year around mid-October.

Carriers must include additional supplemental materials in the CD-ROM to enhance its use and value to providers; and, are free to decide which supplemental materials to include. However, CMS may instruct all carriers to include a specific item(s) as part of the additional supplemental material on the CD-ROM (example: a note from the administrator, a special file, etc.). Carriers need to include an insert, or indicate on the envelope, instructions for providers on how to access the data on the CD. Carriers also need to include information regarding whom the provider can contact if assistance is required.

Each October, carriers should post a notice on their web site regarding the upcoming participation enrollment period reminding physicians and practitioners that the upcoming MPFS will be published on the carriers Web site after the physician fee schedule regulation is put on display.

The carrier mails the participation enrollment CD-ROM and/or hardcopy fee disclosure packages via first class or equivalent delivery service, and schedules the release of material so that providers receive it no later than date provided in a temporary instruction each year.

As part of the final mailing, carriers should send a final CD ROM to central office. The mailing address is:

Director of the Division of Practitioner Claims Processing
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

The CD-ROMs are sent to the following physicians and suppliers in accordance with the following guidelines no later than November 15 of each year, subject to the publication of the Final Rule:

- All physician specialties included in the 01-99 specialty range;
- Independently practicing occupational and physical therapists (specialty 65 and 67);
- Suppliers of diagnostic tests;
- Suppliers of radiology services (including portable x-ray suppliers-specialty 63);
- Multi-specialty clinics (specialty 70);
- Independent laboratories (specialty 69-since they can typically bill for anatomic pathology services paid under the Physician Fee Schedule);
- Mammography Screening Centers (specialty 45);
- Independent Diagnostic Testing Facilities (specialty 47);
- Audiologists (specialty 64); and
- Independently Billing Psychologists (specialty 62).

NOTE: Chiropractors and Mammography Screening Centers do not need to view the entire locality fee schedule report. Therefore, carriers may add separate headings on their web site listing the fee data for the procedure codes that they may receive payment.

Carriers send an annual participation announcement and a blank participation agreement to the following non-participating suppliers:

- Ambulatory Surgical Centers (ASCs) (specialty 49); (Although ASCs must accept assignment for ASC facility services, they may also provide and bill for non-ASC facility services, which do not have to be billed as assigned and which are therefore subject to a participation election); and,

- Supplier specialties other than 51-58; (Supplier specialties 51-58 will receive a separate enrollment package from the National Supplier Clearinghouse).

Carriers may create hard copy fee disclosure reports and send them to specialty 49, and supplier specialties other than 51-58, if cost effective to do so (e.g., carriers determine that fee disclosure to suppliers will reduce the number of more costly supplier inquiries for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for supplier fee disclosure, carriers include a disclaimer advising the supplier that the non-participating fee schedule amounts and limiting charges do not apply to services or supplies unless they are paid for under the Physician Fee Schedule. If carriers elect not to routinely disclose supplier fees with their participation enrollment packages, they must furnish suppliers with their applicable fee schedules or reasonable charge screens upon request.

Instructions for completing the enrollment process for non-durable medical equipment, prosthetic, orthotic, and supplies (DMEPOS) suppliers will be issued under separate cover. Those instructions will address the responsibilities of local carriers, durable medical equipment regional carriers (DMERCs), and the National Supplier Clearinghouse.

C. Minimum Requirements for Disclosure Reports for Posting on the Web and Hard Copies

Carriers must place the following information on the web sites and also in their hard copy disclosure reports.

- Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services when posting this information on the web. CMS provides carriers with complete locality data for all procedure codes with a status indicator of A, T, and R (for which CMS has established the RVUs) on the Medicare Physician Fee Schedule Database (MPFSDB). Included on the MPFSDB are payments for the technical portion of certain diagnostic imaging services (including the technical portion of global imaging services) that are capped at the Outpatient Prospective Payment System (OPPS) amount. Limiting charges are included on the annual disclosure reports of providers who may be subject to the nonparticipant fee schedule amount, if they elect not to participate for a calendar year. The limiting charge equals 115 percent of the nonparticipant fee schedule amount.

For the facility setting differential, the limiting charge is 115 percent of the nonparticipant fee for the differential amount.

The data for Locality Fee Schedule Reports are:

--Header Information – Locality identification (on each report page);

--Procedure Codes – Carriers must array all codes paid under the Physician Fee Schedule. They include global, professional component and technical component entries where applicable:

--Par Amount (nonfacility);

--Par Amount (facility based);

--Non-par Amount (nonfacility);

--Limiting Charge (nonfacility):

--Non-par Amount (facility based); and

--Limiting Charge (facility based);

--Footer Information – The following must be included on the fee disclosure reports:

1. The legend: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association" (on each report page).

NOTE: The CMS has signed agreements with the American Medical Association regarding the use of CPT, and with the American Dental Association regarding the use of CDT, on Medicare contractor Web sites, bulletin boards and other contractor electronic communications. If the carrier uses descriptors, it must use short descriptors. The appropriate CPT copyright year must be inserted each year. For example: the 2006 CPT is copyrighted 2005; the 2007 CPT is copyrighted 2006; in each case, the appropriate year for the copyright is inserted by the contractor.

2. The legend: "These amounts apply when service is performed in a facility setting."

3. The legend: "The payment for the technical component is capped at the OPPS amount."

For the disclosure reports, the carrier shall also provide the anesthesia conversion factors.

In addition, the carrier includes language in a bulletin that provides an explanation of the facility-based fee concept (e.g., facility-based fees are linked to their own separate RVUs independent of the non facility RVUs).

D. Disclosure to Medical Societies and Other Parties

Carriers send first class or equivalent (e.g. UPS), free of charge, a complete fee schedule for the entire State (or your service area if it is other than the entire State) to State medical societies and State beneficiary associations. Carriers may negotiate with them as to the medium in which the information is to be furnished.

Carriers send local medical societies and beneficiary organizations a free copy of their respective locality fee schedule. If a fee schedule for the entire service area is requested by a local medical society or beneficiary organization, furnish one free copy. If more than one copy of a complete fee schedule for the carrier service area is requested, carriers charge for extra copies in accordance with the Freedom of Information Act (FOIA) rules. If a provider requests a fee schedule for a locality in which he/she has no office, carriers may charge them in accordance with FOIA rules.

E. Practitioners Subject to Mandatory Assignment

Some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance. The following practitioners must accept assignment for all Medicare covered services they furnish, and carriers do not send a participation enrollment package to these practitioners:

- Specialty 32 - Anesthesiologist assistants (AAs)
- Specialty 42 - Certified nurse midwives
- Specialty 43 - Certified registered nurse anesthetists (CRNAs)
- Specialty 50 - Nurse practitioners
- Specialty 68 - Clinical Psychologists
- Specialty 71 - Registered dietitians/nutritionists
- Specialty 73 - Mass Immunization Roster Billers
- Specialty 80 - Clinical Social Workers
- Specialty 89 - Clinical nurse specialists
- Specialty 97 - Physician assistants

NOTE: The provider type Mass Immunization Biller (specialty 73) can bill only for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

Although these practitioners will not be invited to officially enroll in the Medicare participation program, carriers treat them as participating practitioners for purposes of various benefits available under that program (See Section 30.3.12 in this Chapter).

NOTE: Although these practitioners do not have to sign participation agreements, carriers must include them in the annual MEDPARD as participating. They also include Rural Health Centers.

Carriers may create and send hardcopy fee disclosure reports to these practitioners if cost effective to do so (e.g., the carrier determines that fee disclosure to these practitioners will reduce or minimize the number of more costly inquiries it receives for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for practitioner fee disclosure, carriers include a disclaimer advising the practitioner that the non-participating fee schedule amounts and limiting charges do not apply to services they furnish. If carriers elect not to routinely disclose practitioner fees, they furnish applicable fees or reasonable charge screens upon request.

The Medicare Participation Agreement and general instructions are on the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf.

F. Supplier Fee Schedule Data

Refer to Chapter 23 for more information.

Clinical Laboratory Fee Schedule

Carriers must:

- Publish clinical diagnostic lab fees in a regularly scheduled bulletin or newsletter.

- Publish clinical laboratory fees in the following format:

  - Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page;

  - Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);

  - Fee Schedule Amount; and

  - Footer Information: The legend “All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association.” (on each report page).

Information regarding release of this data will be issued under separate cover.

DMEPOS Fee Schedule:

Instructions for furnishing DMEPOS fee schedule data will be issued annually by CMS.

G. Fee Schedule Printing Specifications

Carriers are to produce hardcopy disclosure material for no more than two percent of their total number of providers. Carriers have the discretion to produce either one or two percent hardcopy versions. The hard copy fee schedules are to be mailed to providers who are **unable** to access the carrier Web site (i.e., do not have internet access). For those providers, carriers must print fee schedules on 8-1/2 by 11-inch paper, and use a print size that accommodates up to 15 characters per inch. The CMS prior approval for smaller print must be requested in writing from the RO. Requests are to be accompanied by print samples to assist the RO in assessing report readability.

H. Date of HCPCS Update

The annual HCPCS update occurs on January 1 of each year. The annual HCPCS update file will be released electronically in October of each year.

I. Medicare Participation Physicians/Suppliers Directory (MEDPARD)

Annually, within 30 days following the close of the annual participation enrollment process, carriers produce a directory listing only Medicare participating physicians and suppliers and post it on their Web site. Carriers do not print hardcopy participation directories (i.e., MEDPARDs) without regional office prior authorization and advance approved funding for this purpose. Carriers load MEDPARD equivalent information on their Internet Web site. Carriers notify providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. Carriers also inform hospitals and other organizations (e.g., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on the carrier Web site.

Carriers that receive MEDPARD inquires from beneficiaries who do not have access to their Web site will ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(a). Contents

Each directory has two parts. Part I shows the correct Specialty, Name, Address and Telephone Number of each participating Physician, Supplier and Group by geographic area. The address in the directory must be the address of the physician's/supplier's place of business and not a Post Office box number. Part II includes only the name and

telephone number of all Physicians, Suppliers and Groups contained in Part I listed in alphabetic sequence. Telephone numbers may not be omitted. Edit the listings to assure that everyone listed in Part I is also listed in Part II (multiple addresses may be included if appropriate); physicians are listed only once by name in Part II.

When you have only the group name for participating group practices, you may list the names of physician(s) within the group, but only at the group's request. For groups which so request, list the physicians under the group name in alphabetical sequence. Indicate an individual physician's specialty if it differs from other specialties. Show only the group address and telephone number. (NOTE: A group practicing physician who also has solo practices may appear more than once if he is participating in more than on entity.)

Do not list the names of hospital based physicians.

Where a beneficiary would not have personal choice access to a group, (e.g., the group accepts patients by referral only), list only the group name and address. Note that it accepts patients by referral only.

If a physician or supplier has multiple service locations, accommodate this in the directories to the extent possible with the information on the provider file and information obtained during the participation enrollment process.

List all <u>independent</u> RHCs in your area, not necessarily jurisdiction, in the MEDPARD. They are required to accept Medicare payment on claims as payment in full and, therefore, meet the acceptance criteria for a MEDPARD listing even though a participating agreement has not been signed. Do not group independent RHCs with physicians in the directory. List them separately on a full or partial page under the wording shown below. Show the name, address and telephone number of each. Treat the RHC as a group and list only the clinic name and telephone number in Part II of the MEDPARD (the alphabetical listing). Use an indicator so the beneficiary can distinguish between a group and a RHC.

The following wording must appear above the list of independent RHCs:

> "Rural Health Clinics (RHCs) agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible. The independent RHCs in the area are listed below:"

(b). Organization (Geographic, Physician/Supplier/Group, Alphabetic)

Prepare a separate MEDPARD for each geographic area, e.g., depending upon size, one for each metropolitan area or one for each county or group of counties. Your plan must be submitted to RO for approval prior to production. Divide each MEDPARD into two parts.

Divide Part I first alphabetically by geographical location. Within each location, list each specialty. Under the specialty, alphabetically list Physicians, Suppliers and Groups with their addresses and telephone numbers. Include optometry and podiatry as specialties and not as suppliers. Add lay terminology to all specialty headings, e.g., ophthalmology (eye disease), so that they are easily understood by the beneficiary. Do not list any "miscellaneous" or "unknown" specialties. These should default to "General Practice" or "Other."

Part II is a straight alphabetical listing of all Physicians, Suppliers and Groups in the directory, with their telephone numbers. If a physician's or supplier's name and address are the same and listed more than once in Part I, list that individual only once in Part II.

(c). Paper, Print, Binding

Carriers with regional office prior authorization and advanced funding can prepare the MEDPARD in hardcopy (booklet) form on white offset book paper. Size the directory by the number of participating physicians/suppliers in your area. Do not exceed 8 1/2 by 11 inches. Use print comparable to 10 point type or larger which improves the readability of the directory. Use type set print rather than computer listings. Put all geographical location and specialty headings in bold, uppercase lettering.

Bind the directory in an attractive and distinctive cover which displays the red, white and blue emblem of the Medicare participating physician. This emblem must show association with “U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services.” clearly indicate on the front cover that this is a Medicare directory of participating physicians/suppliers. Date the MEDPARD so that older editions will not be confused with subsequent ones.

The back cover should function as an envelope for the directory. Put your name and return address in the upper left corner. Reserve the upper right corner for 3rd class postage. Use address labels, generated from your records of directory requests, to make the directory a self-mailer.

Carriers with regional office prior authorization and advanced funding for the MEDPARD in booklet form must produce it within 45 days following the close of the annual participation enrollment process.

(d). Interpretive Information

Each directory must have a Table of Contents. Include detailed instructions on the organization of the directory. Place your name and toll-free telephone number at the bottom of the instructions in the front of the directory. Include detailed instructions on "how to use the directory," i.e., to locate a participating physician or supplier in a specific area: first, find the correct county in the table of contents; second, look below the county for the city name and find the city's page number; third, turn to the appropriate page and look for the physician or supplier specialty you need; fourth, look for the names of

physicians or suppliers in that specialty. At the top of the instruction page, include the statement: "This directory contains the names, addresses, telephone numbers, and specialties of MEDICARE PARTICIPATING physicians and suppliers. MEDICARE PARTICIPATING physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services."

(e). Dissemination of MEDPARD Information

Within your Medicare service area, inform the following groups how to access the MEDPARD on the carrier Web site:

- Beneficiaries who request to view the MEDPARD; and
- Physicians, suppliers, groups, and clinics listed in the directory who request to view the MEDPARD.

Within 30 days after the close of the annual participation enrollment period, carriers inform the following individuals/groups of the availability of their local MEDPARD on the carrier Web site:

- Congressional offices;
- Quality Improvement Organizations;
- Senior citizen groups and other beneficiary advocacy organizations;
- Social Security Offices;
- State area agencies of the Administration on Aging; and
- Hospitals.

If you receive inquiries from a customer who does not have access to your Web site, ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(f). Alternative Method

You may produce the MEDPARD on diskettes or transmit it electronically. Send alternative mediums to those entities or individuals who wish to receive them in forms other than paper.

Carriers add their local MEDPARDs to their Web sites and inform the various organizations who use the directory of its availability. Publicize Web site MEDPARD access information at least annually in your regularly scheduled newsletters.

(g). Reporting Requirements

Carriers with regional office prior authorization and advanced funding for the MEDPARD in hardcopy form must maintain a record of all hardcopy directories that were distributed. Submit an initial printing/distribution/cost report within 90 days after the close of the annual participation enrollment period. Send the report to your RO and copy CO at the following address:

Director, Division of Practitioner Claims Processing
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Include the following information in your initial report: (1) the number of MEDPARDs initially printed; (2) the number of MEDPARDs distributed to each category in (e) above within 60 days after the close of the annual participation enrollment period; and (3) the cost per directory distributed (e.g., printing and distribution costs).

Submit a year end report no later than 45 days after the end of the fiscal year. On the year end report, include the actual number of MEDPARDs printed and the number of MEDPARDs distributed to each category during the fiscal year. Include the cost per directory distributed on your initial report and include an explanation as to the reason for the adjusted year end cost figure.

J. Furnishing Participating Physician/Supplier Data to Railroad Retirement Board (RRB)

(a). Furnishing RRB with participating information for the general enrollment period:

Within 30 days after the annual participation enrollment period has closed, all carriers must furnish their entire physician/supplier file. The file is to be transmitted to RRB at the same time the MEDPARD is being posted on the carrier Web site. Submit the file in the following format:

1. File Specifications

Carriers send the Provider Participation File (PPF) via CD or cartridge to the RRB carrier. Enter the external label for the file as follows:

FROM:
TO:
DATE:
DATA SET NAME: "Provider Participation File" (PPF).

A. Header Type Specifications

	Field	Position	Picture	Remarks/Field Value

1.	Label	1-3	x (3)	"PPF"
2.	Carrier No.	4-8	9 (5)	Carrier number assigned by CMS.
3.	Date File Updated	9-14	x (6)	MMDDYY

B. Detail Record Specifications.--

	Field	Position	Picture	Remarks/Field Value
1.	TIN/EIN	1-9	9 (9)	Tax identification number used to report income (1099).
2.	UPIN	10-15	x (6)	Unique Physician Identification Number. If not available or applicable, fill with spaces.
3.	Locality	16-17	x (2)	Locality or area designation associated with TIN/EIN.
4.	Current Year Par Indicator	18	x (1)	"Y" = Par "N" = Nonpar
5.	Current Year of Practice	19	9 (1)	1 = First year 2 = Second year 3 = Third year 4 = Fourth year 5 = Established Provider
6.	Carrier PIN	20-29	x(10)	The provider's carrier-assigned provider identification number.
7.	Physician/Supplier Name	30-54	x (25)	Last Name = 14 First Name = 10 Middle Initial = 1 or Corporate Name = 25 The format for provider name is a total of 25 bytes. Individual providers must have a comma between last name, first name, and middle initial (i.e., Smith, John, M). Space one position between multiple words in corporate names (i.e., Jones Medical Supply).
8.	Physician/Supplier Address	55-110	x (56)	Street Address = 30 City = 15 State Code = 2 Zip Code = 9 Space between numerics and words and space between multiple words. Left justify zip codes. The first five zip code spaces must be numeric and the last four spaces can either be numeric or spaces. Separate street address, city and state with

				commas, e.g., "1234 Security Boulevard, Baltimore,MD,567891234"

Carriers send the physician/supplier file to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400
Augusta, GA 30909

(b). Furnishing RRB with participating information for other than the general enrollment period:

After furnishing an annual provider file, inform the RRB carrier, on a flow-basis, of all participating doctors, practitioners and suppliers who enroll after the annual general enrollment period. Carriers send the RRB carrier copies of participation election forms received from physicians, practitioners and suppliers who enrolled after the annual enrollment and, therefore, were not included on the provider file transmitted to the RRB carrier. Transmit copies of such participation enrollment forms via cover letter or fax. Include the following information in your cover letter or fax cover sheet:

- Tax Identification (TIN) or Employer Identification Number (EIN);
- UPIN *or NPI when required*;
- Locality designation associated with the TIN/EIN;
- Current Year of Practice;
- Carrier PIN *or NPI when required*; and
- Participation Effective Date.

NOTE: If any of the above information is entered/displayed on the participation agreement form being transmitted, you do not need to include that piece of information in your cover letter or you may state "see attached participation agreement" for that particular item of information.

Carriers send photocopy participation agreements by mail to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400

Augusta, GA 30909

For participation agreements transmitted via fax call (706) 855-3049.

K. Key Implementation Dates

A detailed schedule of key implementation dates will be provided in an annual temporary instruction in advance of receiving the MPFS Database file. The following outlines significant disclosure activities and anticipated implementation dates. A detailed schedule is provided under separate cover by CMS.

Carriers must:

October:

- Download fee schedules
- Download HCPCS

November:

- Release participation materials and disclosure reports;
- Furnish yearly physician fee schedule amounts to CMS for carrier priced codes;

December:

- Furnish DMEPOS fee schedule and physician fee schedules to State Medicaid Agencies;
- Furnish conversion factors and inflation indexed charge data to the carrier State Medicaid Agencies;
- Process participation elections and withdrawals; and,
- Send a complete fee schedule to the State medical societies and State beneficiary associations.

January:

- Implement annual fee schedule amounts;
- Implement annual HCPCS update;
- Send an updated provider file to the Railroad Retirement Board; and
- Load MEDPARD equivalent information on the carrier Web site.

February:

- Submit participation counts to CMS Central Office via CROWD.