

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 12448</b>	<b>Date: January 11, 2024</b>
	<b>Change Request 13469</b>

**SUBJECT: Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to establish new provider specialty codes and payment instructions for MFTs and MHCs, as authorized by Section 4121 of the Consolidated Appropriations Act, 2023. These payments begin January 1, 2024. All MFTs and MHCs billing Medicare will be required to enroll with Medicare.

**EFFECTIVE DATE: January 1, 2024**

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

**IMPLEMENTATION DATE: February 12, 2024**

**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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N	12/240/Marriage and Family Therapist (MFT) Services
N	12/250/Mental Health Counselor (MHC) Services
R	1/30/30.3.1/Mandatory Assignment on Carrier Claims
R	1/30/30.3.12.1/Annual Open Participation Enrollment Process

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**



# Attachment - Business Requirements

Pub. 100-04	Transmittal: 12448	Date: January 11, 2024	Change Request: 13469
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**SUBJECT: Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)**

**EFFECTIVE DATE: January 1, 2024**

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## I. GENERAL INFORMATION

**A. Background:** Section 4121 of the Consolidated Appropriations Act, 2023, Coverage of MFT Services and MHC Services Under Part B of the Medicare Program, establishes a new Medicare benefit category for MFT services and MHC services furnished by and directly billed by MFTs and MHCs, respectively.

The purpose of this CR is to update the Medicare Claims Processing Manual and Medicare Benefit Policy Manual to reflect Medicare coverage and payment for MFTs and MHCs, effective January 1, 2024.

**B. Policy:** Section 4121 of the Consolidated Appropriations Act, 2023, Coverage of MFT Services and MHC Services Under Part B of the Medicare Program, establishes a new Medicare benefit category for MFT services and MHC services furnished by and directly billed by MFTs and MHCs, respectively. MFT and MHC services are defined as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital). An MFT or MHC is defined as an individual who possesses a master's or doctor's degree, is licensed or certified by the State in which they furnish services, and who has performed at least 2 years or 3,000 hours of clinical supervised experience and meets other requirements as the Secretary determines appropriate.

MFT and MHC services will be paid at 75 percent of the amount determined for payment under the Medicare Physician Fee Schedule. MFT and MHC services are excluded from consolidated billing requirements under the skilled nursing facility prospective payment system. Services furnished by an MFT and MHC are covered when furnished in a rural health clinic and federally qualified health center. In addition, the hospice interdisciplinary team is required to include at least one social worker, MFT or MHC.

### **Section 1861(s)(2)(II) of the Social Security Act - Payment of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH)**

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights and payment for their services to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for the professional services of a MFT or MHC (revenue codes (RC) 96X, 97X or 98X). The Medicare payment amount for MFT and MHC services is 80% of the lesser of the actual charge or 75 percent of the Medicare Physician Fee Schedule (MPFS).

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13469 - 04.1	Contractors shall be aware of the updates to the Medicare Claims Processing Manual - Chapter 12.		X							

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13469 - 04.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.		X			

### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: All other recommendations and supporting information: N/A**

### V. CONTACTS

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

### VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual

## Chapter 1 - General Billing Requirements

### 30.3.1 - Mandatory Assignment on Carrier Claims

*(Rev.12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)*

The following 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 amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, *marriage and family therapists, mental health counselors*, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

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

- Ambulatory surgical center services; (No deductible and 25% coinsurance for colorectal cancer screening colonoscopies {G0105 and G0121) and effective for dates of service on or after January 1, 2008 G0104 also applies);
- Home dialysis supplies and equipment paid under Method II for dates of service prior to January 1, 2011. Refer to Section 30.3.8 for information regarding the elimination of Method II home dialysis for dates of service on and after January 1, 2011;
- Drugs and biologicals; and,
- Ambulance services

When these claims are inadvertently submitted as unassigned, carriers process them as assigned.

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation

Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

Future updates to this section will be communicated in a Recurring Update Notification.

### **30.3.12.1 - Annual Open Participation Enrollment Process**

*(Rev.12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)*

#### **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 Background**

Every year, contractors conduct an open participation enrollment period in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision. The open enrollment period runs from November 15 to December 31.

Until 2004, the Medicare contractors mailed each provider a hardcopy package which included enrollment materials, a paper copy of the Medicare Physician Fee Schedule (MPFS), an Announcement document, the Medicare Participating Physician or Supplier Agreement (Form CMS-460), and a variety of provider education material about the Medicare program. Beginning with the 2005 mailing, CMS directed Medicare contractors to begin using a CD for the participation mailing because it was less expensive than mailing the hardcopy materials.

Beginning with the 2006 mailing, contractors placed the new Medicare fees on their Web sites and did not include the fees on the CDs due to frequent last minute changes to the MPFS. Removing the Medicare fees from the CD provided greater flexibility for updates late in the year due to legislative changes or CMS payment policy decisions.

Since the fee schedules are no longer included on the CD, and the educational materials, as well as the Form CMS-460, are also posted on contractors' Web sites, the value of the CD to the provider community has diminished. Beginning 2011, CMS is directing contractors to produce a postcard mailing, instead of a CD, for eligible physicians, practitioners and suppliers.

#### **B1. Postcard Mailing**

No later than October 31<sup>st</sup> of each year, beginning in 2011, contractors should produce a postcard for the annual open participation enrollment period. Providers that do not have access to the internet must be educated to contact their local contractors to request a hard copy disclosure package. The annual post card will remind the Medicare health professional community to view their local contractor's Web site regarding information for the upcoming open participation enrollment period. The postcard also will remind health professionals that the new MPFS update is posted on their local contractor's Web site.

Carriers/MACs must annotate the postcard with the following message:

#### **Medicare Participating Provider Program**

##### **<Insert Upcoming Year> Participation Enrollment and Fee Disclosure Information**

This is a reminder that the <insert upcoming year> Annual Participation Open Enrollment Period is approaching. The open enrollment period runs mid-November through December 31. Refer to your local Medicare contractor's Web site at <insert the "Medicare Participating Provider" Web site> to obtain more specific information about the Annual Participation Open Enrollment Period. Medicare Physician Fee Schedule for services rendered during <insert upcoming year> are also posted on your local Medicare contractor's Web site.



If you do not have internet access, contact your local Medicare Contractor at <insert contractor's toll free number> to request a hardcopy Participation Enrollment and Information Package which includes the new Medicare fees.

The carrier/MAC mails the participation enrollment postcard 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 the date provided in the annual participation enrollment instruction.

## **B2. Web site**

Each October, carriers/MACs 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/MACs Web site after the physician fee schedule regulation is put on display.

Carriers/MACs must assure providers have access to specific information about the Annual Participation Open Enrollment Period via a single page on their Web site. Carriers/MACs must include the following information and/or links to following on this page: the Annual Announcement, the Medicare Participating Agreement (Form CMS-460), the Medicare Physician Fee Schedule Fee Disclosure, detailed instructions for submitting the participation enrollment forms or disenrollment requests, and any supplemental educational information you see fit. Carriers/MACs need to include information regarding whom the provider can contact if assistance is required. Also, CMS may instruct all carriers/MACs to include a specific item(s) as part of the additional supplemental material on their Web site. (**EXAMPLE:** A note from the administrator, a special file, etc.)

Carriers/MACs must place the new fees and the anesthesia conversion factor(s) on their Web site after the final rule is placed on display. The CMS transmits the Medicare Physician Fee Schedule Database electronically to carriers/MACs each year around late-October. CMS notifies the carrier/MACs that the annual MPFS files, including anesthesia, are available in an email notification. The email notification also contains the file names.

The CMS will furnish carriers/MACs, via a separate instruction, with the participation materials used for the annual participation open enrollment period, including the Announcement, which shall be displayed on contractor's Web site. Carriers/MACs must mail a postcard reminding providers to look at the contractors' Web site for information regarding the annual open participation enrollment period.

## **B3. Physicians/Practitioners/Suppliers**

The postcards 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/MACs may add separate headings on their Web site listing the fee data for the procedure codes that they may receive payment.

Carriers/MACs 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/MACs 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 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
- *Specialty E1 - Marriage and Family Therapists*
- *Specialty E2 - Mental Health Counselors*

**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:
  - o Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page:
  - o Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);
  - o Fee Schedule Amount; and
  - o 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 one 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 independent 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

	<u>Field</u>	<u>Position</u>	<u>Picture</u>	<u>Remarks/Field Value</u>
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.--

	<u>Field</u>	<u>Position</u>	<u>Picture</u>	<u>Remarks/Field Value</u>
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"
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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.

# **Medicare Claims Processing Manual**

## **Chapter 12 - Physicians/Nonphysician Practitioners**

### **Table of Contents** *(Rev.12448; Issued:01-11-24)*

*240 - Marriage and Family Therapist (MFT) Services*

*250 - Mental Health Counselor (MHC) Services*

**240 - Marriage and Family Therapist (MFT) Services**

**(Rev.12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)**

*See Medicare Benefit Policy Manual, Chapter 15, for coverage requirements.*

*Assignment of benefits is required.*

*Payment is at 75 percent of the amount that a clinical psychologist is paid under the physician fee schedule.*

*MFTs are identified on the provider file by specialty code E1.*

**250 - Mental Health Counselor (MHC) Services**

**(Rev.12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)**

*See Medicare Benefit Policy Manual, Chapter 15, for coverage requirements.*

*Assignment of benefits is required.*

*Payment is at 75 percent of the amount that a clinical psychologist is paid under the physician fee schedule.*

*MFTs are identified on the provider file by specialty code E2.*