CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 212	**Date: August 10, 2012**
	Change Request 7884

SUBJECT: New Non- Physician Specialty Code for Centralized Flu

I. SUMMARY OF CHANGES: The intent of this CR is to create a new specialty code for Centralized Flu (C1).

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013

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	6/150/D(1)/Claims Processing Timeliness - All Claims
R	6/170.3/Part E/Interest Payment Data
R	6/400.5/Non-Physician Practitioner/Supplier Specialty Codes
R	6/420/Exhibit

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 212	Date: August 10, 2012	Change Request: 7884

SUBJECT: New Specialty Code for Centralized Flu

EFFECTIVE DATE: **January 1, 2013**
IMPLEMENTATION DATE: January 7, 2013

I. GENERAL INFORMATION

A. Background:

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by that physician or non-physician practitioner. Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Specialty codes are used by CMS for programmatic and claims processing purposes.

B. Policy:

The Centers for Medicare & Medicaid Services (CMS) will establish a new non-physician practitioner specialty code for Centralized Flu. The new non-physician practitioner specialty code for Centralized Flu will be C1.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7884.1	Contractors shall include non-physician practitioner Specialty Code C1 (Centralized Flu) with their submissions for CROWD Form 'F' (Participating Physicians).	X			X						CROWD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

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X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tiffany Stouder, tiffany.stouder1@cms.hhs.gov (410) 786-1854

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

150 - Part D(1) - Claims Processing Timeliness - All Claims

(Rev. 212, Issued: 08-10-12, Effective: 01-01-13, Implementation: 01-07-13)

Pages 2-9 of the CMS-1565 include data on its activity in processing all claims to completion during the reporting period. A claim is counted as processed to completion on the scheduled payment date, which is the date the check is mailed, deposited in the provider's account, or transferred electronically. For non-paid claims, the date of completion is the date the MSN or other notice of final action on the claim is mailed. Data shown must be based on reliable counts of all claims (real and replicate) processing activity. The carrier does not estimate claim counts. It reports only data relating to initial claims (real and replicate) actions. It does not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

"Clean" claims are defined as those that do not require investigation or development external to the carrier's operation on a prepayment basis. Claims which do not meet the definition of "clean" are "other" claims. Claims paid are those for which some payment was made (i.e., payment greater than zero). Claims not paid are those for which no payment was made (i.e., claim charges applied completely toward deductible or fully denied).

On pages 2-9, the carrier reports:

- In column 1, the total number of claims processed to completion;
- In column 2, the number of "clean" claims paid;
- In column 3, the number of "other" claims paid;
- In column 4, the number of "clean" claims not paid;
- In column 5, the number of "other" claims not paid; and
- In column 6, the number of "clean" or "other" claims processed to completion, which were received via electronic media from providers or their billing agencies and read directly into the carrier's claims processing system. The carrier does not count on this line claims that it received in hardcopy and entered using an OCR device. It does not count any claims received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

The data in lines 1 through 37 of pages 2 through 9 represent the number of claims processed in the number of days shown on that line, counting from the date of receipt. Line 38 represents the sum of lines 1 -37. The date of receipt is defined for hard-copy and magnetic tape claims as the date of receipt in the mailroom. For EMC billed via terminal or equivalent, it is the date the claim passes all front-end edits. For split claims, whether required or replicate, the date of receipt is the date of receipt of the original claim material, not the date of the split.

To calculate the processing time for a claim, the carrier subtracts the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, it adds 365 to the Julian date of completion (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 39.

On line 39, the carrier reports the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, it adds the processing times for the claims shown in line 38 of that column, and divides by the number in line 38. It does not use the categories on the report to

calculate the mean PT. Because of the aggregation of claims in lines 34-37, it uses the processing times for individual claims, as explained below, to make this calculation.

Mean PT Calculation for All Claims - To determine the mean PT for all claims:

- Subtract the Julian date of receipt from the Julian date of payment or equivalent action for those not paid for each claim.
- Accumulate the result to cell counter for number of days for all claims.
- Divide this result by the total number of claims.
- Round to one decimal place.

EXAMPLE:

Claim	Julian Date Receipt	Paid	Counter by Days	Counter by Claims
A	87103	87133	30	1
B	87105	87206	101	2
C	87115	87177	62	3
D	87120	87213	93	4
E	87122	87215	93	5
F	87130	87223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472
Mean = 472/6 = 78.6666 = 78.7
The carrier completes the report for each of the following claim types:

Page 2. **Assigned Physician** - It shows the number of assigned claims included on page 9 which involved services billed by physicians. Physicians are identified by specialty codes 01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98, 99 or C0.

Page 3. **Assigned DME** - It shows the number of assigned claims included on page 9 which involved services billed by DME suppliers. DME suppliers are identified by specialty codes 51-58, 87, 88, 96, A0-A8 or *B1*-B5.

Page 4. **Assigned Lab** - It shows the number of assigned claims included on page 9 which involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Page 5. **Assigned Ambulance** - It shows the number of assigned claims included on page 9 which involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Page 6. **Assigned Other** - It shows the number of assigned non-physician claims included on page 9 but not represented on pages 3, 4, or 5.

Page 7. **Unassigned** - It shows the number of unassigned claims (real and replicate) included on page 9.

Page 8. **Participating Physician** - It shows the number of claims included on page 9 involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

Page 9. **All Claims** - It shows the total number of claims (real and replicate) processed during the month.

170.3 - Part E - Interest Payment Data

(Rev. 212, Issued: 08-10-12, Effective: 01-01-13, Implementation: 01-07-13)

The carrier reports on Page 12 of the CMS-1565 data on the claims on which it paid interest because it paid the claims after the required payment date per §9311 of the Omnibus Reconciliation Act of 1986 (OBRA 1986). It bases data shown on reliable counts of all claims processing activity, not on estimates. It reports data on initial claims only. It includes in the report all claims requiring interest payments in the month. It reports claims in the month the date of payment falls. (For a discussion of interest payments refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Sections 80.2.2 and 80.2.2.1).

The carrier completes the report for each column as follows:

Column 1. Total - Data for all claims (real and replicate) for which interest payments were made during the month.

Column 2. Assigned Physician - Data for the assigned claims included in column 1 which involved services billed by physicians. Physicians are identified by specialty codes 01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98, 99 or C0.

Column 3. Assigned DME - Data for the assigned claims included in column 1 that involved services billed by DME suppliers. DME suppliers are identified by specialty codes 51-58, 87, 88, 96, A0-A8 or *B1*-B5.

Column 4. Assigned Lab - Data for the assigned claims included in column 1 that involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Column 5. Assigned Ambulance - Data for the assigned claims included in column 1 that involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Column 6. Assigned Other - Data for the assigned non-physician claims included in column 1 but not represented in columns 3, 4, or 5.

Column 7. Unassigned - Data for the unassigned claims included in column 1.

Column 8. Participating Physician - Data for claims involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

On line 1, the carrier shows the number of claims on which it paid interest in the reporting month. It reports on line 2 the number of claims included in line 1 for which it made payment one day after the required payment date (e.g., the required payment date is 17 days after receipt for participating physician claims received in FY 1992.) (See §9311 of OBRA 1986.) Data for lines 3-10 are similar to those for line 2.

The carrier calculates the number of days late by subtracting the Julian date of the required payment date from the Julian date of payment.

On line 11, it shows the amount paid in interest for claims reported in line 1. On lines 12-20, it shows the amount paid in interest for claims reported in lines 2-10, respectively. It shows dollar amounts on lines 11-20 to the nearest penny, and includes the decimal point.

400.5 - Non-Physician Practitioner/Supplier Specialty Codes

(Rev. 212, Issued: 08-10-12, Effective: 01-01-13, Implementation: 01-07-13)

The following list of codes and narrative describe the kind of medicine non-physician practitioners or other healthcare providers/suppliers practice.

Code	Non-Physician Practitioner/Supplier Specialty Codes
15	Speech Language Pathologist in Private Practice
31	Intensive Cardiac Rehabilitation (ICR)
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner
59	Ambulance Service Supplier, e.g., private ambulance companies, funeral homes
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Clinical Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Licensed Clinical Social Worker
88	Unknown Supplier/Provider
89	Certified Clinical Nurse Specialist
95	Reserved
97	Physician Assistant
C1	*Centralized Flu*

NOTE: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".

420 - Exhibit

(Rev. 212, Issued: 08-10-12, Effective: 01-01-13, Implementation: 01-07-13)

Exhibit 1 - Participating Physician/Supplier Report - Screen 1

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine

	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
SPECIALTY CODE/GROUP	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
01-PHY								
02-PHY								
03-PHY								
04-PHY								
05-PHY								
06-PHY								
07-PHY								
08-PHY								
09-PHY								
10-PHY								
11-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 2

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

12 Osteopathic Manipulative Medicine
13 Neurology
14 Neurosurgery
15 Speech Language Pathologist in Private Practice
16 Obstetrics/Gynecology
17 Hospice and Palliative Care
18 Ophthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
21 Cardiac Electrophysiology
22 Pathology
23 Sports Medicine
24 Plastic and Reconstructive Surgery

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
12-PHY								
13-PHY								
14-PHY								
15-NPP								
16-PHY								
17-PHY								
18-PHY								
19-PHY								
20-PHY								
21-PHY								
22-PHY								
23-PHY								
24-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 3

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

25 Physical Medicine and Rehabilitation
26 Psychiatry
27 Geriatric Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
31 Intensive Cardiac Rehabilitation (ICR)
32 Anesthesiologist Assistant
33 Thoracic Surgery
34 Urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
25-PHY								
26-PHY								
27-PHY								
28-PHY								
29-PHY								
30-PHY								
31-SUP								
32-NPP								
33-PHY								
34-PHY								
35-PHY								
36-PHY								
37-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 4

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetist (CRNA)
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facility (DTL)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
38-PHY								
39-PHY								
40-PHY								
41-PHY								
42-NPP								
43-NPP								
44-PHY								
45-SUP								
46-PHY								
47-SUP								
48-PHY								
49-SUP								
50-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 5

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

59 Ambulance Service Supplier
60 Public Health/Welfare Agency
61 Volunteer Health/Charitable Agency
62 Clinical Psychologist (Billing Independently)
63 Portable X-Ray Supplier (Billing Independently)
64 Audiologist (Billing Independently)
65 Physical Therapist in Private Practice
66 Rheumatology
67 Occupational Therapist in Private Practice
68 Clinical Psychologist
69 Clinical Laboratory (Billing Independently.)
70 Single or Multispecialty Clinic or Group Practice
71 Registered Dietitian/Nutrition Professional

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
59-SUP								
60-SUP								
61-SUP								
62-NPP								
63-SUP								
64-NPP								
65-NPP								
66-PHY								
67-NPP								
68-NPP								
69-SUP								
70-PHY								
71-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 6

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

72 Pain Management
73 Mass Immunization Roster Biller
74 Radiation Therapy Centers
75 Slide Preparation Facilities
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivist)
82 Hematology
83 Hematology/Oncology
84 Preventative Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
72-PHY								
73-SUP								
74-SUP								
75-SUP								
76-PHY								
77-PHY								
78-PHY								
79-PHY								
80-NPP								
81-PHY								
82-PHY								
83-PHY								
84-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 7

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

85 Maxillofacial Surgery
86 Neuropsychiatry
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Reserved
97 Physician Assistant
98 Gynecological Oncology
99 Unknown Physician Specialty

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
85-PHY								
86-PHY								
88-SUP								
89-NPP								
90-PHY								
91-PHY								
92-PHY								
93-PHY								
94-PHY								
95-RES								
97-NPP								
98-PHY								
99-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 8

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

C0 Sleep Medicine
C1 Centralized Flu

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
C0-PHY								
C1-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 9

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

Total Physicians - The contractor enters in the appropriate column the total of all specialty codes applicable to physicians.

Total LLPs - The contractor enters in the appropriate column the total of all specialty codes applicable to limited license physicians.

Total NPPs - The contractor enters in the appropriate column the total of all specialty codes applicable to non-physician practitioners.

Total Physicians/LLPs/NPPs - The contractor enters in the appropriate column the sum of all physicians, LLPs and NPPs.

Total Suppliers - The contractor enters in the appropriate column the total of all specialty codes applicable to suppliers.

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
TOTALs								
PHYs*								
LLPs*								
NPPs*								
PHYs/LLPS/NPPs*								
SUPs*								

* These lines do not represent specific specialty codes. They are the totals of the specialty sub-groups.