

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1171	Date: FEBRUARY 2, 2007
	Change Request 5476

NOTE: This transmittal is being re-communicated June 19, 2007 to correct a type-o in business requirement 5476.6.1. Business Requirement 5476.6.1 should say "American Medical Association," not "American Medicare Association." The transmittal number and issue date will not change and all other information remains the same.

SUBJECT: Revisions to the Medicare Physician Fee Schedule (MPFS) Disclosure Format

I. SUMMARY OF CHANGES: Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of diagnostic imaging procedures. For the TC of diagnostic imaging services including the TC portions of the global imaging services, the payment will be capped based on the Outpatient Prospective Payment System (OPPS). Based on this change, contractors shall place a denotation mark on their fee schedule disclosure reports that identifies the services for which the payment has been held to the OPPS cap amount.

New / Revised Material

Effective Date: July 1, 2007

Implementation Date: July 2, 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	1/30/3.12.1/Carrier Participation and Billing Limitations

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 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: 1171	Date: February 2, 2007	Change Request: 5476
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SUBJECT: Revisions to the Medicare Physician Fee Schedule (MPFS) Disclosure Format

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of diagnostic imaging procedures. For the TC of diagnostic imaging services including the TC portions of the global imaging services, the payment will be capped based on the Outpatient Prospective Payment System (OPPS). Based on this change, contractors shall place a denotation mark on their fee schedule disclosure reports that identifies the services for which the payment has been capped at the OPPS payment amount.

B. Policy: The purpose of this Change Request is to revise the current Medicare Physician Fee Schedule Database (MPFSDB) disclosure report format to display the denotation mark for diagnostic imaging procedures for which payment is capped at the OPPS payment amount. The limitation of the physician fee schedule amount to the level of the OPPS payment amount applies to the TC portion when the global service is billed, and when the TC portion is billed alone. To determine if OPPS payment applies to the TC of diagnostic imaging services, contractors shall compare the physician fee schedule amount to the OPPS amount. If the lowest amount is the OPPS amount, contractors shall mark their disclosure reports as being capped at the OPPS payment amount.

Contractors shall update the existing American Medical Association (AMA) copyright statement on the current disclosure report to include the year for which the Current Procedural Terminology (CPT) codes are copyrighted. In addition, contractors will have the ability to update the copyright year from one year to the next in order to accommodate annual publications of the CPT. The AMA copyright statement is displayed on all disclosure reports (hard-copy, or on a Web site).

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A	D	F	C	D	R	Shared-	OTHER
		/	M	I	A	M	H	System	
		B	E		R	E	H	Maintainers	

		M A C	M A C		R I E R	R C	I	F I S S	M C S	V M S	C W F	
5476.1	<p>For the technical component of diagnostic imaging services on the Medicare physician fee schedule, contractors shall disclose (hard-copy or Web site) the lower of either the physician fee schedule amount, or the OPPS payment amount, beginning with the July 2007 MPFSDB quarterly update.</p> <p>NOTE: The limitation of the physician fee schedule amount to the level of the OPPS payment amount applies to the TC portion when the global service is billed, and when the TC portion is billed alone.</p>	X			X				X			
5476.2	<p>Contractors shall revise the current Medicare physician fee schedule disclosure report format to include PAR, Non-PAR, and Limiting Charge for the technical component of diagnostic imaging services capped at the OPPS payment amount.</p>	X			X				X			
5476.3	<p>Contractors shall expand the “NOTE” field on the Medicare physician fee schedule disclosure report to list denotation marks side-by-side to identify codes capped at the OPPS payment amount.</p>	X			X				X			
5476.3.1	<p>For codes with allowances that are capped at the OPPS payment amount, contractors shall use the new denotation of “C” in the “NOTE” field next to the procedure code and display the following new message at the bottom of the disclosure report:</p> <p>“C - The payment for the technical component is capped at the OPPS amount.”</p> <p>NOTE: The “C” can appear right beside other denotation marks. For example: When both the OPPS amount and facility payment apply for a single code, the disclosure will show C# in the “NOTE” field. When the code is only capped at the OPPS amount, the “NOTE” field will show C.</p>	X			X				X			
5476.4	<p>To create the disclosure, contractors shall access MPFSDB field 31cc, the OPPS payment amount field. A “1” in this field will identify those services subject to the comparison between the Medicare physician fee schedule amount and the OPPS payment</p>	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R E R	D M R C	R H R I	Shared-System Maintainers				OTHER
		M A C	M A C		I E R			F I S	M C S	V M S	C W F	
	amount.											
5476.4.1	Contractors shall compare the OPPS payment amount to the Medicare physician fee schedule amount and place the lower of these two amounts on their disclosure reports. NOTE: The contractor only needs to denote a diagnostic imaging procedure with a "C" on their disclosure report if that procedure is being capped at the OPPS payment amount. Otherwise, if the procedure IS NOT being capped at the OPPS payment amount, the "C" denotation mark is not needed.	X			X				X			
5476.5	For carrier-priced codes (i.e., codes with an MPFSDB Status Indicator "C") where the contractor has established their own fee, contractors shall compare the OPPS payment amount to their carrier-priced allowance and take the necessary steps needed to place the lower of these two amounts on their disclosure report, using the new denotation mark in 5476.3.1 when applicable. NOTE: Some carrier file maintenance or manual input may be necessary in order to properly disclose status "C" codes for contractors that have established a fee.	X			X				X			
5476.6	Contractors shall change the existing AMA copyright statement on the current disclosure report (hard-copy or Web site) to be able to include the year for which the CPT is copyrighted, and have the ability to update the copyright year from one year to the next.	X			X				X			
5476.6.1	Contractors shall use the following AMA copyright statement for any 2007 disclosure reports, on each report page, produced after the implementation of this instruction: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2006 by the American Medical Association."	X			X				X			
5476.6.2	Contractors shall insert the appropriate CPT	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R E R	D M R R I C	R H I	Shared-System Maintainers				OTHER
		M A C	M A C		I E R			F I S	M C S	V M S	C W F	
	copyright year on all disclosure reports for all future years. 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.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R E R	D M R R I C	R H I	Shared-System Maintainers				OTHER
		M A C	M A C		I E R			F I S	M C S	V M S	C W F	
	None.											

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410-786-2033, kathleen.kersell@cms.hhs.gov, or Pat Gill, 410-786-1297, Patricia.gill@cms.hhs.gov

Post-Implementation Contact(s): Appropriate regional office.

VI. FUNDING

A. For TITLE XVIII Contractors, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use only one of the following statements:

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 specified 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.

30.3.12.1 - Carrier Participation and Billing Limitations

(Rev. 1171, Issued: 02-02-07, Effective: 07-01-07, Implementation: 07-02-07)

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 OPSS 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 inquiries 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"

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 (if applicable);
- Locality designation associated with the TIN/EIN;
- Current Year of Practice;
- Carrier PIN; 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.