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# Medicare

## Carriers Manual

### Part 3 - Claims Process

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Department of Health and  
Human Services (DHHS)  
Centers for Medicare and  
Medicaid Services (CMS)

Transmittal 1808

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#### CHANGE REQUEST 2369

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
17001 – 17002 (Cont.)	17-3 – 17-11 (14 pp.)	17-3 – 17-10 (16 pp.)

**MANUALIZATION--*EFFECTIVE DATE: N/A***  
***IMPLEMENTATION DATE: N/A***

Section 17000, Mandatory Assignment and Participation Program, is revised to list two new practitioners' services that must accept assignment. Also, revised the CMS Web site for the Medicare Participation Agreement and general instructions.

Section 17001, Participation Program, is revised to reflect new policies and procedures for the Participation Program, to correct spelling, and changing HCFA to CMS.

Section 17001.1, Participation Program and Billing Limitations, is revised to update new policies and procedures to the Participation Program and Billing Limitations, and to correct misspelled words.

Section 17002, Limiting Charge, is revised to reflect new policies and procedures for Limiting Charge, and to show the change to the "effective date" section of the Medicare Participating Physician or Supplier Agreement.

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

**These instructions should be implemented within your current operating budget.**

## 17000. MANDATORY ASSIGNMENT AND PARTICIPATION PROGRAM

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 practitioners' services to which mandatory assignment applies are services of:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- CRNAs;
- Nurse midwives;
- 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.

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 accept assignment on all Medicare claims. Such an agreement is known as a participation agreement. (See Exhibit 1.) The Medicare Participation Agreement and general instructions are on the CMS Web site.

## 17001. PARTICIPATION PROGRAM

A. Eligibility.--All practitioners and suppliers eligible to receive payments under Part B of Medicare may choose to enter into a participation agreement. This includes practitioners whose services are subject to mandatory assignment. The reason why it could still be appropriate for such practitioners to enter into a participation agreement is because the mandatory assignment provisions apply only to the particular practitioner service benefit (e.g., nurse practitioner services). Thus, for example, if a nurse practitioner is eligible to bill for, and is indeed billing under, Part B for something other than a nurse practitioner service (e.g., an EKG tracing), the mandatory assignment provision of the law does not apply to that other service. However, if the nurse practitioner has entered into a participation agreement, that agreement requires that the nurse practitioner accept assignment for any service for which he or she submits a Medicare Part B claim.

B. Participation Enrollment Period.-- Carriers conduct an enrollment period on an annual basis in order to provide eligible practitioners and suppliers with the opportunity to enroll in or terminate enrollment in the participation program. They are given specific instructions each year regarding the dates during which the enrollment period is in effect.

C. Circumstances in Which A Participating Physician or Supplier is Not Required to Accept Assignment for Covered Services.--A participating physician or supplier is not required to accept assignment for covered services when an entity (other than the beneficiary) which is eligible to request direct payment from the Medicare program for the services pays the physician or supplier and the physician or supplier accepts that payment as full payment.

For example, a private supplementary health benefits plan may pay the physician an amount which

The physician or supplier accepts as payment in full and then collect the Part B payment directly from the Medicare program. This procedure, called indirect payment or payment to organizations, permits a physician or supplier to submit a single claim for the Medicare and private plan benefits to the private health benefits plan. The physician or supplier may accept plan payment in excess of the Medicare approved charge.

The availability of this procedure depends on the extent to which health benefit plans are eligible and choose to use it. The indirect payment procedure is also available to nonparticipating physicians or suppliers.

D. Entities Eligible to Enter Into Agreement to Be Participating Physicians or Suppliers.--Any person or organization which is authorized to accept assignment of Medicare benefits for covered services may enter into a participating physician agreement. This includes (but is not limited to):

- o Practitioners such as physicians, podiatrists, dentists, optometrists, and chiropractors;
- o Hospitals, medical groups, and other entities which are authorized to bill and to receive payment for physician services;
- o Organizations such as group practice prepayment plans, prepaid health plans, HMOs, and competitive medical plans which submit claims to Medicare carriers; and
- o Suppliers such as independent physical therapists, medical equipment supply companies, independent laboratories, ambulance services, and portable x-ray suppliers.

E. Applicable Rules When Physicians Work for a Hospital or Medical Group.--The following rules apply when physicians work for (or are members of) a hospital, medical group, or other entity:

- o Except in the case of university medical centers, if a hospital, medical group, or other entity bills and receives payment for physician services in the name of the entity (rather than have the individual physicians bill and receive payment in their own names), one participation agreement by the entity binds all physicians with respect to any services furnished for the entity. The individual physicians do not enter into participation agreements.

**NOTE:** In university medical centers, when individual departments bill under the name and provider identification number of the department, decisions for or against participation can be made on a departmental basis.

- o If a physician who is associated with a particular entity has an individual practice outside the scope of the practice for which the entity bills and receives payment, he or she may choose whether to participate with respect to his/her outside practice without regard to the participation status of the entity.
- o If individual physicians who work for an entity bill and receive payment in their own names for the services furnished for the entity, they make individual decisions as to whether to participate. These decisions apply both to the physicians' services for the entity and to any outside practice.

F. Services Subject to Agreement.--The participation agreement applies to items and services for which payment is made on a fee-for-service basis by Medicare Part B carriers. A participating agreement applies to all items and services in all localities and under all names and identification numbers under which the participant does business.

The participant lists all names and identification numbers under which the participant submits claims to the carrier. This means all names and numbers of the legal entity entering into the agreement, whether that entity is a sole proprietorship, partnership, or corporation.

If the participant opens offices in another carrier jurisdiction during the term of the agreement, he or she must file a photocopy of the agreement with that carrier.

G. Acknowledgment of Receipt.--Acknowledge receipt of an agreement by sending the physician or supplier a photocopy or carbon copy of the agreement which has been annotated with the effective date.

H. Where to File Agreement.--Treat an agreement as valid if it is filed with any Medicare carrier in a timely manner.

A new participant must file an original agreement with the carrier in their region and a photocopy of the agreement by a date that CMS specifies on an annual basis with any other carriers which have assigned the participant a physician identification number and to which the participant submits claims. When submitting a photocopy of the agreement to a carrier, the new participant must identify in the letter transmitting the photocopy all names and identification numbers under which the participant submits claims to that carrier and indicate the name of the carrier to which the original agreement was mailed or delivered and the date it was mailed or delivered.

If the new participant enters into a valid agreement but does not also timely file a photocopy of the agreement with another carrier with which the participant does business, it may be too late for the participant to be listed in that carrier's directory of participating physicians. Nevertheless, the agreement is still binding, and it is important for the physician or supplier to submit a photocopy of the agreement to that carrier, even if late, because of advantages of the agreement which are still available with late filing.

It is not necessary for the new participant to file a photocopy of the agreement with **Palmetto GBA, the carrier for railroad retirement beneficiaries**.

I. Duration of Agreement.--An agreement entered into, or continuing in effect, for a given year remains in effect through that year and may not be revoked during that period.

The agreement is renewed automatically for each 12-month period thereafter unless, during the enrollment period provided near the end of the 12-month period, the participant gives proper written notice of a wish to terminate the agreement at the end of its current term. Proper written notice means written notice to all carriers with whom the participant has filed the agreement or a copy of the agreement.

The CMS may terminate the agreement if it finds, after notice and opportunity for hearing, that the participant has substantially failed to comply with the agreement. There are also civil and criminal penalties, identical to those for assignment violations, which may be imposed for violation of the agreement.

J. When New Physician or Supplier in Area May Enter Into Agreement.--A physician/supplier who has enrolled in the Medicare program and wishes to become a participating physician/supplier must file an agreement with a Medicare carrier within 90 days after either of the following events:

- The participant is newly licensed to practice medicine or another health care profession;
- or
- The participant first opens offices for professional practice or other health care business in a particular carrier service area or locality (regardless of whether the participant previously had or retains offices elsewhere).

If a physician has an arrangement with a hospital, medical group, or other entity under which the entity bills in its name for his/her services, changes that arrangement and then begins to bill in his/her own name, he/she is considered to be first opening offices, even though he/she practices in the same location.

The participating enrollment package is included with the CMS-855 form for new enrollees. Carriers must furnish a special participating agreement form for new physicians or suppliers upon request or at the time you assign the new physician or supplier an identification number.

When the agreement is filed on one of the above bases, it is effective on the date of filing, i.e., the date the participant mails (postmark date) the agreement to the carrier or delivers it to the carrier. The initial period of the agreement may be less than 12 months. Otherwise, the terms of the agreement are the same as those of an agreement entered into by other physicians or suppliers. The agreement applies to all services in all localities. The physician or supplier must submit the original agreement to the carrier in their region and photocopies to all carriers with whom he or she deals.

If a physician or supplier first enters into an agreement after publication of your directory, his or her name is not included in the directory until subsequent reprinting. This may not occur until the next annual publication date. Make the names of those physicians or suppliers entering into agreements after the initial deadline available on the toll free telephone lines as each physician or supplier enters into an agreement.

#### 17001.1 Participation Program and Billing Limitations.--

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.--For the annual participation enrollment CMS will furnish carriers with a participation announcement and fact sheet to send physicians and suppliers. 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.

The Medicare Physician Fee Schedule Database, will be transmitted electronically to carriers by CMS on or about October 18 of each year. Carriers mail the annual participation materials to 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.

Carriers must send an annual participation enrollment announcement, fact sheet, and, unless otherwise specified, a complete locality disclosure report to physicians and suppliers eligible to enroll. Include a blank participation agreement in packages sent to the following non-participating physicians and suppliers:

- o All physician specialties included in the 01-99 specialty range; (An entire locality fee schedule report need not be furnished to chiropractors. At a minimum, furnish chiropractors with fee data for procedure codes which they may receive payment.)

- o Independently practicing occupational and physical therapists (specialty 65 and 67);
- o Suppliers of diagnostic tests;
- o Suppliers of radiology services (including portable x-ray suppliers--specialty 63);
- o Multi-specialty clinics (specialty 70);

- o Independent laboratories (specialty 69-since they can typically bill for anatomic pathology services paid under the Physician Fee Schedule);
- o Mammography Screening Centers (specialty 45). (You may limit your disclosure for **Mammography Screening Centers to procedure codes which they may receive payment.**)
- o **Independent Diagnostic Testing Facilities (specialty 47);**
- o Audiologists (specialty 64); and
- o Independently Billing Psychologists (specialty 62).

For the following suppliers **carriers** send an annual participation announcement and a fact sheet. They include a blank participation agreement for the following non-participating suppliers:

- o 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);
- o Ambulance Companies (specialty 59); and
- o Supplier specialties other than 51-58; (Supplier specialties 51-58, 87, 88 and A5-A7 will receive a separate enrollment package from the National Supplier Clearinghouse).

**Carriers** may create fee disclosure reports and send them to specialty 49, 59 and supplier specialties other than 51-58 with their participation enrollment packages, if cost effective to do so (e.g., you 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.

C. Minimum Requirements for Disclosure Reports. --**Carriers must** use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services. **Carriers** provide complete locality data for all procedure codes with a status indicator of A, L, T, and R (for which **CMS** has established the RVUs) on the Medicare Physician Fee Schedule Database. **They** include limiting charges on the annual disclosure reports of providers who may be subject to the non-participant fee schedule amount, if they elect not to participate for a calendar year. The limiting charge equals 115 percent of the non-participant fee schedule amount.

**The data** for Locality Fee Schedule reports are:

- **Procedure Codes (including professional and technical components modifiers, as applicable);**
- **Par amount (non-facility);**
- **Par amount (facility-based);**
- **Non-par amount (non-facility);**
- **Limiting charge (non-facility);**
- **Non-par amount (facility-based); and**
- **Limiting charge (facility-based).**

For CY disclosure reports also provide the anesthesia conversion factors.

The following two statements must be included on the fee disclosure reports:

"All Current Procedural Terminology (CPT) codes and descriptors are copyrighted by the American Medical Association." (on each report page).

"These amounts apply when service is performed in a facility setting."

Include 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).

In addition to sending disclosure reports in the participation enrollment package, you may, at your discretion, and within the constraints of your authorized budget, load the fees on your Internet Web site or electronic bulletin board if you have either. If you choose to use descriptors, you must use the short descriptors. CMS has signed an agreement with the American Medical Association regarding use of CPT on Medicare Contractor Web sites, bulletin boards, and other electronic communications.

Mail participation enrollment/fee disclosure packages via first class or equivalent delivery service, and schedule the release of material so that providers receive it no later than date provided in a program memorandum each year.

Physicians and suppliers enrolled in the Medicare program under the Form CMS-855 process do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment. However, there is a 5 percent reduction in the Medicare approved amounts if the physician or his reassignee does not participate. Participation is an election that is optional to suppliers, even those that have to bill assigned.

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 the 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 your 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.--**The** following practitioners must accept assignment for all Medicare covered services they furnish:

- Physician assistants (specialty 97);
- **Anesthesiologist assistants (AAs) (specialty 32);**
- Certified registered nurse anesthetists (CRNAs) (specialty 43);
- Certified nurse midwives (specialty 42);
- Clinical nurse specialists (specialty 89);
- Nurse practitioners (specialty 50);

- Clinical Psychologists (specialty 68);
- Clinical Social Workers (specialty 80);
- Registered Dietitians/Nutritionists (specialty 71); and
- Mass Immunization Roster Billers (specialty 73).

Do not send a participation enrollment package to these practitioners.

Although these practitioners will not be invited to officially enroll in the Medicare participation program, treat them as a participating for purposes of various benefits available under that program. These benefits include:

- No 5 percent reduction in their Medicare approved amount.
- "Beneficiaries with Medigap (private supplemental insurance) may assign the payment on the supplemental claim. Carriers will forward the necessary data, thereby relieving the provider of having to file a second claim."
- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD).

**NOTE:** Although these practitioners do not have to sign participation agreements, include them in the annual MEDPARD as participating. Also include rural health centers.

Carriers may create and send fee disclosure reports to these practitioners if cost effective to do so (e.g., the carriers determine that fee disclosure to these practitioners will reduce or minimize the number of more costly inquiries you receive 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.

#### F. Supplier Fee Schedule Data--

Clinical Laboratory Fee Schedule:

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;
- Fee Schedule Amount; and
- Footer Information: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 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 under separate cover.

G. Fee Schedule Printing Specifications.-- **Carriers** must print all fee schedules on 8 1/2 by 11 inch paper. They use print size that accommodates up to 15 characters per inch. **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.

**Carriers** may provide the disclosure report in hardcopy, disk or electronic form, depending on cost considerations and arrangements you make with providers. **Carriers** may not require providers to accept a medium other than paper if they do not prefer an alternative medium.

H. 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. MEDPARDS.--**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 your 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 your Web site.**

J. Key Implementation Dates.--**A detailed schedule of key implementation dates will be provided in a annual program memorandum in advance of receiving the Medicare Physician Fee Schedule Database file. The following outlines significant disclosure activities and anticipated implementation dates. A detailed schedule is provided under separate cover by CMS.**

October:

- o Download fee schedules
- o Download HCPCS

November:

- o Release participation announcement, fact sheet, blank participation agreements and disclosure reports;
- o Furnish yearly physician fee schedule amounts to **CMS** for local and carrier priced codes;

December:

- o Furnish DME fee schedule and physician fee schedules to State Medicaid agencies;
- o Furnish conversion factors and inflation indexed charge data to your State Medicaid agencies;
- o Process participation elections and withdrawals;
- o Send a complete fee schedule to the State medical societies and State beneficiary associations.

January:

- o Implement annual fee schedule amounts for physician services;
- o Implement annual HCPCS update;
- o Send an updated provider file to the Railroad Retirement Board in accordance with **Medicare Carriers Manual, Part 3, §§7552-7552.1; and**
- o **Load MEDPARD equivalent information on your Web site.**

February:

- o Submit participation counts to central office by February of each year. (Separate instructions will be released for furnishing this information.)

## 17002. LIMITING CHARGE

Effective January 1, 1991, the maximum allowable actual charge (MAAC) for non-participating physicians (see §5253) is replaced by the limiting charge, as defined. The limiting charge also effectively replaces the special charge limits for overpriced procedures (see §5254), anesthesia associated with cataract and iridectomy surgery (see §5255), A-mode ophthalmic ultrasound and intraocular lenses (IOLs (see §5256)), and designated specialty (see §5263) because the limiting charge is always less than or equal to the special charge limits.

Services Rendered Prior to January 1, 1994

For services rendered prior to January 1, 1994, the limiting charge applies to unassigned claims for physicians' services as defined in §1861(s)(1) of the Act, regardless of who is billing for the physicians' service. The limiting charge applies to unassigned claims for the following services when furnished by a non-participating physician:

- o Physicians' services;
- o Services and supplies furnished incident to a physician's service that are commonly furnished in a physician's office;
- o Diagnostic tests; and
- o Radiation therapy services (including x-ray, radium, and radioactive isotope therapy, and materials and services of technicians).

**NOTE:** The limiting charge does not apply to services furnished by independently practicing physical and occupational therapists or to services furnished by a supplier. Also, the limiting charge does not apply to services excluded from the physician fee schedule (e.g., drugs).

Services Rendered On or After January 1, 1994

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them, if the services/supplies are covered by the Medicare program and are provided on or after January 1, 1994:

- o Physicians' services;
- o Services and supplies furnished incident to a physician's services that are commonly furnished in a physician's office;
- o Outpatient physical therapy services furnished by an independently practicing physical therapist;
- o Outpatient occupational therapy services furnished by an independently practicing occupational therapist;
- o Diagnostic tests; and
- o Radiation therapy services (including x-ray, radium, and radioactive isotope therapy, and materials and services of technicians).

**NOTE:** This means that, effective for services/supplies provided on or after January 1, 1994, the limiting charge applies to drugs and biologicals provided incident to physicians' services, to physical therapy services provided by independently practicing physical therapists, and to occupational therapy services provided by independently practicing occupational therapists. These changes are made because of provisions in OBRA 1993. OBRA 1993 expanded the limiting charge to apply to services/supplies which the law permits Medicare to pay for under the physician fee schedule methodology but which Medicare has chosen to pay for under some other method. "Incident to" drugs and biologicals, previously excluded from the limiting charge because of their exclusion from physician fee schedule payment, are, effective January 1, 1994, still excluded from physician fee schedule payment but subject to the limiting charge. Also, OBRA 1993 applies the limiting charge to all of the above listed services/supplies, regardless of who provides or bills for the services/supplies. No longer are services of suppliers and other nonphysicians, such as independently practicing physical and occupational therapists, excluded from the limiting charge.

In 1991 and 1992, the limiting charge is specific to each physician.

Except as noted, in 1991, the limiting charge is the same percentage (but no more than 25 percent) above the 1991 prevailing charge for nonparticipating physicians as the percentage by which a physician's 1990 MAAC exceeded the 1990 prevailing charge for nonparticipating physicians. (See Example 1.)

For evaluation and management (E&M) services in 1991, the limiting charge is the same percentage (but no more than 40 percent) above the 1991 prevailing charge for nonparticipating physicians as the percentage by which a physician's 1990 MAAC exceeded the 1990 prevailing charge for nonparticipating physicians. (See Example 2.)

Prevailing charges as reduced by the overpriced procedures reduction (see §5254) or as limited by the designated specialty provision (see §5263) are used in calculating the limiting charge.

When payment is based on a special charge screen, i.e., the outpatient limit (see §5031), multiple surgical procedures (see §4149), assistants at surgery (see §5039), designated specialty (see §5263), and radiology services paid on a reasonable charge basis but limited to the radiology fee schedule amount (see §5265), the 1991 limiting charge is equal to 125 percent of the payment allowance (140 percent for E&M services).

Effective January 1, 1992, the limiting charge is the same percentage (but no more than 20 percent) above the 1992 fee schedule amount for nonparticipating physicians as the percentage by which the 1991 limiting charge exceeded the 1991 prevailing charge for nonparticipating physicians. (See

## Example 3.)

For new physicians (including a new physician who is a member of or part of a group), the limiting charge is equal to 120 percent of the reduced fee schedule amount for services furnished on or before December 31, 1993. The new physician payment limits are repealed effective for services furnished on or after January 1, 1994. (See §15050.)

Effective January 1, 1993, the limiting charge is simply 115 percent of the fee schedule amount for nonparticipating physicians. (See Example 4.)

Charges to either a payer for whom Medicare is secondary or to a payer under the indirect payment procedure (see §7065) are not subject to the limiting charge if the physician accepts the payment received as full payment (i.e., if there is no payment by the beneficiary).

**Physicians, non-physician practitioners, and suppliers must take assignment on claims for drugs and biologicals furnished on or after February 1, 2001, under §114 of the Benefits Improvement and Protection Act (BIPA).**

Notify physicians that they may round the limiting charge to the nearest dollar if they do so consistently for all services.

## EXAMPLE 1: (Non-E&amp;M Service)

	<u>Dr. X</u>	<u>Dr. Y</u>
A. 1990 MAAC	\$1150.00	\$1300.00
B. 1990 Nonparticipating Prevailing Charge	\$1000.00	\$1000.00
C. Percentage Difference Between A and B	15%	30%
D. 1991 Nonparticipating Prevailing Charge	\$1050.00	\$1050.00
E. 1991 Limiting Charge (D increased by lower by C or 25%)	\$1207.50	\$1312.50

## EXAMPLE 2: (E&amp;M Service)

	<u>Dr. X</u>	<u>Dr. Y</u>
A. 1990 MAAC	\$1300.00	\$1500.00
B. 1990 Nonparticipating Prevailing Charge	\$1000.00	\$1000.00
C. Percentage Difference Between A and B	30%	50%
D. 1991 Nonparticipating Prevailing Charge	\$1050.00	\$1050.00
E. 1991 Limiting Charge (D increased by lower of C or 40%)	\$1365.00	\$1470.00

## EXAMPLE 3:

	<u>Dr. X</u>	<u>Dr. Y</u>
A. 1991 Limiting Charge	\$1207.50	\$1312.50
B. 1991 Nonparticipating Prevailing Charge	\$1050.00	\$1050.00
C. Percentage Difference Between A and B	15%	25%
D. 1992 Nonparticipating Fee Schedule Amount	\$1100.00	\$1100.00
E. 1992 Limiting Charge (D increased by lower of C or 20%)	\$1265.00	\$1320.00

## EXAMPLE 4:

	<u>Dr. X</u>	<u>Dr. Y</u>
A. 1993 Nonparticipating Fee Schedule Amount	\$1200.00	\$1200.00
B. 1993 Limiting Charge (A increased by 15%)	\$1380.00	\$1380.00

OMB No. 0938-0373

**MEDICARE**  
**PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT****Name(s) and Address of Participant\*****Physician or Supplier  
Identification Code(s)\***

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment** - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. **Effective Date** - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective \_\_\_\_\_.

3. **Term and Termination of Agreement** - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

\_\_\_\_\_  
Signature of participant  
(or authorized representative  
of participating organization)

\_\_\_\_\_  
Title  
(if signer is authorized  
representative of organization)

\_\_\_\_\_  
Date

CMS-460

Office phone number \_\_\_\_\_  
(including area code)

\*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

Received by \_\_\_\_\_  
(name of carrier)

Effective date \_\_\_\_\_

Initials of carrier official \_\_\_\_\_

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