Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-53 **Date: OCTOBER 20, 2000**

CHANGE REQUEST 1373

SUBJECT: Calendar Year (CY) 2001 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

The annual participation enrollment program for calendar year 2001 will commence on November 17, 2000, and will run through December 31, 2000.

The purpose of this Program Memorandum (PM) is to furnish you with material needed for this year's participation enrollment effort. The following documents are attached:

- A Year 2001 Fact Sheet;
- A blank Participation Agreement;
- A Participation Announcement; and
- An errata sheet, addressing errors in the descriptors for G0179 and G0184 on the disclosure reports.

The information contained in the 2001 Fact Sheet is to be treated as confidential. The Fact Sheet is subject to change during the regulation clearance process and must not be released prior to the publication of the Final Rule implementing the Fee Schedule for Physician Services for CY 2001. We will notify the regional offices if any information in the fact sheet changes during the clearance process.

Reproduce these attachments for your participation enrollment/fee disclosure packages. See Medicare Carriers Manual (MCM) §17001.1 for fee disclosure guidelines. For CY 2001 disclosure reports, display fee data as follows:

- Procedure code (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 2001 disclosure reports, also provide the anesthesia conversion factors.

Mail participation enrollment/fee disclosure packages via first class or equivalent delivery service, and schedule the release of this material so that providers receive it no later than November 17, 2000.

Physicians and suppliers enrolled in the Medicare program under the HCFA Form-855 process do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment.

HCFA's Center for Health Plans and Providers will release the Medicare Physician Fee Schedule Database (MPFSDB) and the anesthesia conversion factors to carriers electronically. The regional offices will be notified and will inform you as to the date the files will be available for downloading by contractors. The MPFSDB will contain the CY 2001 fee schedule amounts for procedure codes with status indicators of A, T, D, H and R if Relative Value Units (RVUs) have been established by HCFA. Carriers are also to include drug allowance (status code E) for disclosure purposes. The anesthesia conversion factors will be provided in a separate file in Excel format.

HCFA-Pub. 60B

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

> "All Current Procedural Terminology (CPT) codes and descriptors copyrighted by the American Medical Association."
>
> "These amounts apply when service is performed in a facility setting." (This statement should be made applicable to those services subject to a differential based on place of service. It replaces any language referring to "site of service.")

Publish a bulletin using language similar to that contained in Program Memorandum B-98-46. Include 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 website or electronic bulletin board if you have either. You must use the short descriptors. HCFA has signed an agreement with the American Medical Association regarding use of CPT on Medicare contractor websites, bulletin boards and other electronic communications. You will receive specific instructions regarding your responsibilities under the agreement.

Furnishing Participation Physician/Supplier Information

Do not print hardcopy participation directories (i.e., MEDPARDs) for CY 2001 without regional office prior authorization and advance approved funding for this purpose. Supplemental budget requests (SBRs) for CY 2001 MEDPARD directories will not be approved. Load MEDPARD-equivalent information on your Internet website (if you have one). Notify providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. 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 website.

If website access is not available (e.g., you do not have a website or the inquirer does not have website access capability), ascertain the nature and scope of each request and furnish the desired participation information via phone or letter.

Online Participating Physician Directory

As part of the ongoing effort to provide Medicare beneficiaries with information to help them make health care choices, the Health Care Financing Administration (HCFA) will be launching an online national participating physician directory at www.medicare.gov, HCFA's beneficiary Website. The directory will be released November 15, 2000, and will be accessible from the home page under the section titled *Participating Physician Directory*. Initially, this directory will contain names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment on claims for all services. It will later be expanded to include supplier information.

The information in the database comes form the Unique Physician Identification Number (UPIN) Registry which was provided by you. Information about the directory will be included in the Dear Doctor letter released to Medicare participating physicians in late Fall. **Please be aware that we have instructed them to contact you directly if their information appearing on the Website is incorrect, has changed, or does not appear.** The directory will be updated monthly. Corrections or changes to the information will be reflected on the Website, the month after you submit an update to the UPIN registry.

Key Implementation Dates

Following is a summary of participation enrollment activities and target implementation/action dates:

October 2000

- Download Medicare physician fee schedule files;
- Download HCPCS files; and
- Download anesthesia conversion factors from Excel file.

October-November 2000

- Print and assemble participation enrollment packages.

November 2000

- Release 2001 participation announcement fees, fact sheet, and blank participation agreements via first class mail or equivalent delivery service for receipt no later than November 17, 2000.

November-December 2000

- Process participation elections and withdrawals.

January 2001

- Process elections and withdrawals received after December 31, 2000, but postmarked prior to January 1, 2001; and

- Send an updated provider file to the Railroad Retirement Board Carrier (see MCM Part 3, §§7552-7552.1).

February 2001

- Submit participation counts to HCFA Central Office by February 15, 2001.

The effective date for this PM is November 17, 2000.

The implementation date for this PM is November 17, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after November 17, 2001.

Contractors should direct questions to the appropriate regional office. Regional office staff can direct their questions on carrier operations to Melvia Page on (410) 786-4727 and payment policy to Joan Mitchell on (410) 786-4508.

Attachments

2001 FACT SHEET

FOR PHYSICIANS AND OTHER PROVIDERS: KEY NEWS FROM MEDICARE FOR 2001

Billing and business staff: Please share this with physicians and other providers.

Provider Toll Free Lines

In order to improve our service to providers, the Health Care Financing Administration (HCFA) is converting existing provider customer service telephone lines at Medicare contractors from "toll" to "toll-free." The toll-free telephone service will reduce physicians' and other providers' cost of doing business with Medicare. Once the installation is completed, no Medicare physician, provider, supplier, or agent acting on their behalf will have to pay long-distance charges to talk to Medicare contractors. Your Medicare carrier will announce their toll-free number as soon as this conversion is complete, and if you call the toll line after the conversion, you will be informed of the new toll-free number at that time. Please note that this conversion applies only to lines used for voice inquiries. Lines used by providers to transmit data to Medicare contractors are not being changed.

Participating Physician Directory

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The information in the database comes from the Unique Physician Identification Number (UPIN) Registry and has been provided by your Medicare Carrier. **If your information is incorrect, or has changed, please contact your Medicare Carrier to have it updated.** If you are a Medicare Participating Physician but are not listed in the directory, please contact your Medicare Carrier to have it correct your participating physician status in the UPIN Registry. The directory will be updated monthly. Corrections or changes to your information will be reflected on the website the month after the UPIN registry is updated.

New Information in Publications and Websites

This information may help physicians and other providers to have more successful Medicare billing and to better understand Medicare requirements.

- Local medical review policies. This new website, www.lmrp.net, still being enlarged and improved, lists the Local Medical Review Policies for every Medicare contractor.

- Education modules. This HCFA website, www.hcfa.gov/medlearn, contains a growing collection of educational modules and other basic Medicare information.

- Medicare carrier websites. Your Medicare Carrier now has a website at which they, for example, announce education activities and upcoming events and maintain a monthly listing of the most frequently asked questions and areas of concern/confusion.

- Medicare and You 2001. This beneficiary handbook contains information that is also very useful for the offices of physicians and other providers. Call 1-800-MEDICARE to order a free copy.

- Compliance Guidance for Individual Physicians and Small Group Practices. The Compliance Guidance provides a step by step roadmap for physician practices to follow when establishing a voluntary compliance program. However, it is also instructive to all practices, even if they are not implementing a compliance program, as the introduction and appendices to the Compliance Guidance clarify the Office of Inspector General's (OIG) position concerning medical audits and law enforcement priorities regarding physicians. The appendices serve as an educational resource for practices to obtain plain language explanations of Federal fraud and abuse laws and additional information concerning possible risk areas for the practice. The Compliance Guidance is available at www.hhs.gov/oig (go to the Electronic Reading Room and then to Compliance Guidances) or by calling the OIG Public Affairs office at 202/619-1343.

- Medical Review by Medicare Carriers - Progressive Corrective Action. HCFA recently communicated with our contractors about medical review, and we believe that physicians and their staff may also find this information to be helpful. The Program Memorandum puts together in one place the processes contractors are to use in conducting medical review of physicians and other providers. The instructions emphasize that education and feedback are essential to the medical review process, notes that decisions to conduct medical review need to be data driven, and highlights that the amount of review be only that necessary to address an identified problem. See: www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.

Beneficiary Right to an Itemized Statement

The law now requires that if a Medicare beneficiary submits a written request to you for an itemized statement for any Medicare item or service, you must furnish this statement within 30 days of the request. Failure to fulfill this request may subject the provider to a civil monetary penalty of $100 for each unfulfilled request. Since most physicians' practices have established an itemized billing system for internal accounting procedures and for billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. While the law does not specify the contents of an itemized statement, suggestions for the type of information that might be helpful for a beneficiary to receive on any statement include: beneficiary name, date(s) of service, description of items or services furnished, number of units furnished, provider charges, and a internal reference or tracking number. If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are: amounts paid by Medicare, beneficiary responsibility for coinsurance, and Medicare claim number. The statement could also include a name and telephone number for the beneficiary to call if there are further questions.

Plan now: Expect Flu Vaccine Supply Delays

The Centers for Disease Control and Prevention report that there will be a substantial delay in the availability of some portion of influenza vaccine for the 2000-01 season. Although full quantities should ultimately be available, much of the vaccine will be distributed later in the season than usual. Therefore, providers are encouraged to continue vaccination efforts for all groups into December and later as long as the vaccine is available. Production of vaccine will continue through December, so providers who administer all of their supply early in the season and still have unvaccinated high-risk patients should plan to order and administer additional vaccine in December.

Physician Fee Schedule Information

Revisions to the 2001 Medicare Physician Fee Schedule affect the amount you will receive when providing services to a Medicare beneficiary. Below is a summary of the major changes effective January 1, 2001, as well as other useful information. Full physician fee schedule information is attached.

Continuation of the Transition to Resource-Based Practice Expense Payments

Section 121 of the Social Security Act of 1994 required a methodology for a resource-based system for determining practice expense RVUs for each physician service. The Balanced Budget Act of 1997 amended section 1848(c) requiring the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource based practice expense RVUs becoming fully effective in 2002. The transition formula for 2001 is 25 percent of the charge-based RVUs and 75 percent of the resource-based RVUs.

Screening Mammography

Screening mammography services are billed using code 76092, and diagnostic mammography services are billed using code 76091. The physician fee schedule contains the maximum allowable amount for 76091. However, the same payment rules do not apply for 76092 as a result of the law's special provisions for screening mammography. The allowable amount for 76092 is the lowest of the actual charge, the statutory cap, or the physician fee schedule amount for 76091. The year 2001 update for the cap is 2.1 percent. Therefore, the payment limit for 2001 is $69.23 for the global procedure; $22.15 for the professional component; and $47.08 for the technical component.

Critical Care Relative Value Units

The definition of critical care codes have been revised for 2001 by the AMA CPT Editorial Panel. Based on these revisions, we are increasing the work RVUs for critical care services and value the physician work at 4.0 RVUs for CPT code 99291 and 2.0 RVUs for CPT code 99292.

Care Plan Oversight in Skilled Nursing Facilities and Hospices

For 2001, the CPT changed the definition of care plan oversight services, CPT codes 99375 and 99378. These new codes are not consistent with Medicare's coverage policy. Therefore, we have established new HCPCS codes G0181 and G0182 (care plan oversight) that are consistent with our coverage criteria and will no longer recognize CPT 99375 and 99378.

Payment and Coding for Physician Certification/Re-certification of Home Health Services

We will now pay separately for the services involved in physician certification/recertification and development of plan of care for Medicare-covered home health services. For this, we have established two additional HCPCS codes G0180 and G0179, for the 2001 physician fee schedule. G0180 is to be used when the patient has not received Medicare covered home health services for at least 60 days. G0179 is to be used for re-certification after a patient has received services for at least 60 days (or one certification period).

Observation Care Codes

We have provided clarifying policy concerning use of observation care codes (99234-99236). To receive payment for these codes, the patient must be in observation status for a minimum of 8 hours; otherwise, only the admission code (99218-99220) should be billed.

Ocular Photodynamic Therapy and Other Ophthalmological Treatments

We are establishing codes and national payment amounts for ocular photodynamic therapy. In addition, we are establishing codes for certain other ophthalmic procedures which will be carrier priced. Coverage for all of these procedures, including ocular photodynamic therapy, is carrier determined. However, we are considering establishment of national coverage policy. Your carrier will inform you when the decision is made.

Electrical Bioimpedance

Relative value units have been assigned to Electrical Bioimpedance (EB) which is a noninvasive method of determining cardiac output. This service is currently carrier priced.

Antigen Immunotherapy

We are revising the definition of a "dose" of allergen immunotherapy (CPT code 95165) to define a dose as a one cc aliqout from a single multidose vial. In addition, the limitation on antigen supply has been changed to reflect industry standards and guidelines. The limitation of duration of potency for allergy extracts is changed from 12 weeks to 12 months.

Physician Encounter Data Requirements

The Balanced Budget Act required HCFA to implement comprehensive risk adjustment for Medicare-Choice Organizations (M+COs) beginning in 2004. Comprehensive risk adjustment captures diagnoses from multiple sites of care including inpatient hospital, hospital outpatient, and physician encounters. Each M+CO is required to begin submitting physician encounter data to HCFA for dates of service beginning on October 1. October 1, 2000 through June 30, 2001 is a start-up period. During this period, M+COs and physicians are expected to identify and resolve any difficulties in obtaining and submitting encounter data to HCFA. The M+COs with which you contract may be contacting you soon, if they haven't already, about these encounter data requirements.

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 on the following January 1.

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.

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

b. The Health Care Financing Administration 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 Health Care Financing Administration 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

Office phone number
(including area code)

Received by
(name of carrier)

Effective date

Initials of carrier official

HCFA-460

Announcement
About Medicare Participation for Calendar Year 2001

All physicians, practitioners and suppliers must make their calendar year (CY) 2001 Medicare participation decision by December 31, 2000.

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2001.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies (such as drugs and biologicals) provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, and radiology services, your Medicare fee schedule amounts are 5% higher if you participate.

Also, regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have nonemployment-related Medigap coverage and who assign both their Medicare and Medigap payments to participants. After we have made payment, we automatically send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

The numbers choosing to participate continue to grow. During CY 2000, 88.3 percent of all physicians, practitioners and suppliers are billing under Medicare signed participation agreements - this was a 3.7 percent increase over the number of CY 1999 participants.

WHAT TO DO

If you choose to be a participant in CY 2001:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement enclosed and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in CY 2001:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective January 1, 2001. This written notice must be postmarked prior to January 1, 2001.

Hold on to this announcement during this enrollment period. You may want to refer to it again before making your decision regarding Medicare participation for CY 2001.

We hope you will decide to be a Medicare participant in CY 2001.

Please call _____ if you have any questions or need further information on participation.

IMPORTANT

ERRATA SHEET

The fact sheet is correct, but there are two errors on the code descriptors on the disclosure reports:

The descriptor for HCPCS code G0179 should read as follows: "MD recertification HHA patient" Although the descriptor for the code is incorrect as shown on the fee schedule disclosure report, the payment amounts shown for G0179 are correct.

The descriptor for HCPCS code G0184 should read as follows: "Ocular photodynamic Tx, 2nd eye." Although the descriptor for the code is incorrect as shown on the fee schedule disclosure report, the payment amounts shown for G0184 are correct.