

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 702

Department of Health &
Human Services

Centers for Medicare &
Medicaid Services

Date: OCTOBER 7, 2005

Change Request 4030

SUBJECT: Manualization for Physician/Practitioner/Supplier Participation Agreement and Assignment Carrier Claims and Carrier Rules for Limiting Charge

I. SUMMARY OF CHANGES: The purpose of this instruction is to place information into the Medicare Claims Processing Manual that did not transition from the old Medicare Carriers Manual, sections 17000, 17001, 17002, 7551, and 7552.

NEW/REVISED MATERIAL

EFFECTIVE DATE: N/A

IMPLEMENTATION DATE: N/A

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	1/30/30.3/Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims
R	1/30/30.3.1/Mandatory Assignment on Carrier Claims
R	1/30/30.3.9/Filing Claims to a Carrier for Nonassigned Services
R	1/30/30.3.12/Carrier Annual Participation Program
R	1/30/30.3.12.1/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 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	None.								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: N/A</p> <p>Implementation Date: N/A</p> <p>Pre-Implementation Contact(s): April Billingsley, april.billingsley@cms.hhs.gov and Mel Page-Lasowski, Melvia.Pagelasowski@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Appropriate Regional Office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.</p>
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*Unless otherwise specified, the effective date is the date of service.

30.3 - Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

Institutional providers (those that bill *Fiscal Intermediaries (FIs)*) are paid direct by the FI. In contrast, physicians, practitioners, and suppliers that bill the carrier may choose to enter into a participation agreement.

Carrier “Participating Providers” are paid at 100 percent of the physician fee schedule and must accept assignment (must accept program payment as payment in full, except for any unmet deductible and coinsurance). “Non-participating providers” are paid at 95 percent of the physician fee schedule and may accept assignment on a claim-by-claim basis.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. This is covered in the instructions in later chapters for each service type.

30.3.1 - Mandatory Assignment on Carrier Claims

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary’s liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, *registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.*

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

- Ambulatory surgical center services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs *and biologicals*; and,
- Ambulance services

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

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

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

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. *Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS web site.*

30.3.9 - Filing Claims to a Carrier for Nonassigned Services

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

A - General

Payment for Part B services furnished by a physician (or supplier) is made:

- To the beneficiary on the basis of an itemized bill (nonassigned claims); or
- To the physician (or supplier) who provided covered services on the basis of an assignment of benefit payments where the approved charge is the full charge for the services.

NOTE: For services furnished on or after September 1, 1990, physicians and suppliers must complete and submit both assigned and nonassigned Part B claims for beneficiaries.

B - Conflicting Claims

Carriers must establish controls to detect and prevent payment for assigned and unassigned claims received for the same service (as well as duplicate assigned or duplicate unassigned claims).

If an appropriate assigned claim is received after an unassigned *claim* has been paid, carriers do not pay the subsequent claims. Where an enrollee's claim based on an unpaid bill is received and benefits are payable, carriers make payment to him/her unless there is some definite basis for believing that payment has been assigned, e.g., the physician or supplier is a "participating" provider or the bill from a nonparticipating physician or supplier shows that assignment may have been made.

Carriers are instructed to inform physicians that, if they wish to be sure of receiving Part B benefits, they should accept assignment at the time services are furnished and that their submission of claims to the carrier should not be unduly delayed.

30.3.12 - Carrier Annual Participation Program

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A) (702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

For providers (including physicians and suppliers) who have enrolled in Medicare, to sign a participation agreement (Form CMS-460) is to agree to accept assignment for all covered services that are provided to Medicare patients. The benefits of signing a participation agreement include:

- No 5 percent reduction in the Medicare approved amount.*
- Beneficiaries with Medigap coverage (private supplemental insurance) may assign the payment on the supplemental claim to the provider or supplier. Under the current mandatory Medigap (claim-based) crossover process, beneficiaries must assign payment on their claims to a participating provider or supplier as a condition for their claims to be forwarded to their Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer, in turn, must pay the participating provider or supplier directly, thereby relieving the need of having to file a second claim. (Refer to the Medicare Claims Processing Manual, Chapter 28, Section 70.6, for more information regarding the eligibility-file based crossover process.)*
- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the carrier web site.*
- Participants receive direct and timely reimbursement from Medicare.*

Refer to [§30.3.1](#) for processing instructions for claims for practitioner services inadvertently submitted as unassigned.

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 or supplier* 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 that 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):

- Practitioners such as physicians, podiatrists, dentists, optometrists, and chiropractors;
- Hospitals, medical groups, and other entities which are authorized to bill and to receive payment for physician services;
- Organizations such as group practice prepayment plans, prepaid health plans, HMOs, and competitive medical plans which submit claims to Medicare carriers; and
- 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:

- 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.

- 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.
- 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 includes 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

Carriers acknowledge receipt of an agreement by sending the physician or supplier a photocopy of the agreement, which has been annotated with the effective date.

H - Where to File Agreement

An agreement is 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 Board* beneficiaries. *The new participant's carrier will furnish Palmetto GBA with participating physician/supplier data (see Section 30.3.12.1.J. of this chapter).*

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

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.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

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 *publication*. This may not occur until the next annual publication date. Carriers must 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.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

30.3.12.1 - Carrier Participation and Billing Limitations

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A) (702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

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. On a CD-ROM, carriers send the annual participation materials and, unless otherwise specified, a complete locality Medicare Physician Fee Schedule Database (MPFSDB) disclosure report to physicians and suppliers eligible to enroll. 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.).

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 the CD-ROM 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 fee disclosure reports and send them to specialty 49, and supplier specialties other than 51-58 with their participation enrollment packages, 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

Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services. They provide complete locality data for all procedure codes with a status indicator of *A, T, and R* (for which CMS has established the RUVs) on the Medicare Physician Fee Schedule Database. They include limiting charges 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 statements 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).*
 2. *The legend “These amounts apply when service is performed in a facility setting.”*

For *the* disclosure reports, the carrier shall also provide the anesthesia conversion factors.

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 nonfacility RVUs).

In addition to sending disclosure reports in the participation enrollment package, the carrier *must* load the fees on its Internet Web site or electronic bulletin board. If *the carrier* chooses to use descriptors, it must use the short descriptors. The CMS has signed agreements with the American Medical Association regarding use of CPT, *and with the American Dental Association regarding use of CDT*, on Medicare Contractor Web sites, bulletin boards, and other electronic communications.

The carrier mails participation enrollment/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.

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/her 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 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 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.

F - Supplier Fee Schedule Data

Refer to Chapter 23 for more information.

Clinical Laboratory Fee Schedule

Carriers must:

- Publish clinical diagnostic lab fees in a regularly scheduled bulletin or newsletter.
- Publish clinical laboratory fees in the following format:
 - o Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page;
 - o Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);
 - o Fee Schedule Amount; and
 - o Footer Information: The legend “All *Current Procedural Terminology (CPT)* codes and descriptors *are copyrighted* (appropriate year) *by the* American Medical Association.” (on each report page).

Information regarding release of this data will be issued under separate cover.

DMEPOS Fee Schedule:

Instructions for furnishing DMEPOS fee schedule data will be issued annually by CMS.

G - Fee Schedule Printing Specifications

*Carriers are to produce paper fee schedules for no more than 2 percent of their provider population. The paper fee schedules are mailed to providers who are **unable** to use the CD-ROM and may not contain the additional supplemental information. For those providers, carriers must print fee schedules on 8-1/2 by 11-inch **paper**, and use a print size that accommodates up to 15 characters per inch. The CMS prior approval for smaller print must be requested in writing from the RO. Requests are to be accompanied by print samples to assist the RO in assessing report readability.*

H - Date of HCPCS Update

The annual HCPCS update occurs on January 1 of each year. The annual HCPCS update file will be released electronically in October of each year.

I - *Medicare Participation Physicians/Suppliers Directory* (MEDPARD)

Annually, within 30 days following the close of the annual participation enrollment process, carriers produce a directory listing only Medicare participating physicians and suppliers and post it on their web site. Carriers do not print hardcopy participation directories (i.e., MEDPARDs) without regional office prior authorization and advance approved funding for this purpose. Carriers load MEDPARD equivalent information on their Internet Web site. Carriers notify providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. Carriers also inform hospitals and other organizations (e.g., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on the carrier Web site.

Carriers that receive MEDPARD inquires from beneficiaries who do not have access to their web site will ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(a). Contents

Each directory has two parts. Part I shows the correct Specialty, Name, Address and Telephone Number of each participating Physician, Supplier and Group by geographic area. The address in the directory must be the address of the physician's/supplier's place of business and not a Post Office box number. Part II includes only the name and telephone number of all Physicians, Suppliers and Groups contained in Part I listed in alphabetic sequence. Telephone numbers may not be omitted. Edit the listings to assure that everyone listed in Part I is also listed in Part II (multiple addresses may be included if appropriate); physicians are listed only once by name in Part II.

When you have only the group name for participating group practices, you may list the names of physician(s) within the group, but only at the group's request. For groups which so request, list the physicians under the group name in alphabetical sequence. Indicate an individual physician's specialty if it differs from other specialties. Show only the group address and telephone number. (NOTE: A group practicing physician who also has solo practices may appear more than once if he is participating in more than one entity.)

Do not list the names of hospital based physicians.

Where a beneficiary would not have personal choice access to a group, (e.g., the group accepts patients by referral only), list only the group name and address. Note that it accepts patients by referral only.

If a physician or supplier has multiple service locations, accommodate this in the directories to the extent possible with the information on the provider file and information obtained during the participation enrollment process.

List all independent RHCs in your area, not necessarily jurisdiction, in the MEDPARD. They are required to accept Medicare payment on claims as payment in full and, therefore, meet the acceptance criteria for a MEDPARD listing even though a participating agreement has not been signed. Do not group independent RHCs with physicians in the directory. List them separately on a full or partial page under the wording shown below. Show the name, address and telephone number of each. Treat the RHC as a group and list only the clinic name and telephone number in Part II of the MEDPARD (the alphabetical listing). Use an indicator so the beneficiary can distinguish between a group and a RHC.

The following wording must appear above the list of independent RHCs:

“Rural Health Clinics (RHCs) agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible. The independent RHCs in the area are listed below:”

(b). Organization (Geographic, Physician/Supplier/Group, Alphabetic)

Prepare a separate MEDPARD for each geographic area, e.g., depending upon size, one for each metropolitan area or one for each county or group of counties. Your plan must be submitted to RO for approval prior to production. Divide each MEDPARD into two parts.

Divide Part I first alphabetically by geographical location. Within each location, list each specialty. Under the specialty, alphabetically list Physicians, Suppliers and Groups with their addresses and telephone numbers. Include optometry and podiatry as specialties and not as suppliers. Add lay terminology to all specialty headings, e.g., ophthalmology (eye disease), so that they are easily understood by the beneficiary. Do not list any "miscellaneous" or "unknown" specialties. These should default to "General Practice" or "Other."

Part II is a straight alphabetical listing of all Physicians, Suppliers and Groups in the directory, with their telephone numbers. If a physician's or supplier's name and address are the same and listed more than once in Part I, list that individual only once in Part II.

(c). Paper, Print, Binding

Carriers with regional office prior authorization and advanced funding can prepare the MEDPARD in hardcopy (booklet) form on white offset bookpaper. 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 the 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>
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1.	<i>TIN/EIN</i>	<i>1-9</i>	<i>9 (9)</i>	<i>Tax identification number used to report income (I099).</i>
2.	<i>UPIN</i>	<i>10-15</i>	<i>x (6)</i>	<i>Unique Physician Identification Number. If not available or applicable, fill with spaces.</i>
3.	<i>Locality</i>	<i>16-17</i>	<i>x (2)</i>	<i>Locality or area designation associated with TIN/EIN.</i>
4.	<i>Current Year Par Indicator</i>	<i>18</i>	<i>x (1)</i>	<i>“Y” = Par “N” = Nonpar</i>
5.	<i>Current Year of Practice</i>	<i>19</i>	<i>9 (1)</i>	<i>1 = First year 2 = Second year 3 = Third year 4 = Fourth year 5 = Established Provider</i>
6.	<i>Carrier PIN</i>	<i>20-29</i>	<i>x(10)</i>	<i>The provider's carrier-assigned provider identification number.</i>
7.	<i>Physician/Supplier Name</i>	<i>30-54</i>	<i>x (25)</i>	<i>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).</i>
8.	<i>Physician/Supplier Address</i>	<i>55-110</i>	<i>x (56)</i>	<i>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"</i>

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*.

