

Part 2

Becoming a Medicare Provider

This section introduces billers to the general rules for becoming a Medicare Part B provider, as either a physician or supplier. Although the clinical decisions of what services a patient may need or receive in your setting is the responsibility of the treating physicians and other non-physician healthcare providers, the billing personnel of any provider's office are the principal point of contact between the patient, the treating clinician, and the Medicare claims processing contractor. In this capacity, the provider's billing personnel must be aware of the many rules and regulations that apply to the

setting for which they are submitting claims, as well as the limiting charge placed on services billed on a nonassigned claim. This section discusses the various types of Part B providers under Medicare, the general rules and processes with which individuals and groups/clinics must comply in order to enroll as a Medicare Part B provider, and the various Medicare reimbursement systems that affect physicians and suppliers.

WHAT ARE THE TYPES OF MEDICARE PROVIDERS?

The Medicare Program recognizes a broad range of types of facilities and individual providers and suppliers to furnish the necessary services and supplies to meet the healthcare needs of its beneficiaries. As discussed in Part 1, Introduction to Medicare, Part B physicians and suppliers furnish services and supplies that are only paid through the Medicare Part B benefit, and submit claims to carriers or Durable Medical Equipment Regional Carriers (DMERCs). Part B providers include:

- ❖ Physicians;
- ❖ Nurse practitioners;
- ❖ Clinical psychologists;
- ❖ Physical therapists in private practice;
- ❖ Ambulance service suppliers;
- ❖ Independent diagnostic testing facilities;
- ❖ Suppliers of Durable Medical Equipment (DME), prosthetics, orthotics, or other medical supplies; and
- ❖ Other non-physician providers.



ENROLLING AS A MEDICARE PROVIDER (OR UPDATING ENROLLMENT STATUS)

Physicians wishing to receive payment for Medicare services must complete and submit the appropriate Form CMS-855 provider/supplier enrollment application to the Centers for Medicare & Medicaid Services (CMS). This form requests general information and documentation to ensure that a provider is qualified and eligible to enroll in the Medicare Program. The completed Form CMS-855 and documentation are sent to the appropriate provider enrollment department. The enrollment department verifies the information and documentation, and then the state agency will approve the application.

If the state agency approves the application, the enrollment department will notify the applicant. Notification includes the provider's unique Medicare billing number that is used in all communication with the payment contractor. Table 2-1 contains a list of the agencies that the

various types of physicians and suppliers must contact to enroll as a Medicare provider, or to update provider status. In addition, the table indicates whether Medicare requires an on-site survey/certification process for that type of setting.



State Requirements for Provider Type Certification

States may have additional requirements for certification as a certain provider type. Additional information regarding state certification requirements can be accessed at www.cms.hhs.gov/Providers/enrollment/ on the Web.

GENERAL ENROLLMENT PROCESS

Medicare has different enrollment processes depending upon the type of provider submitting the application.

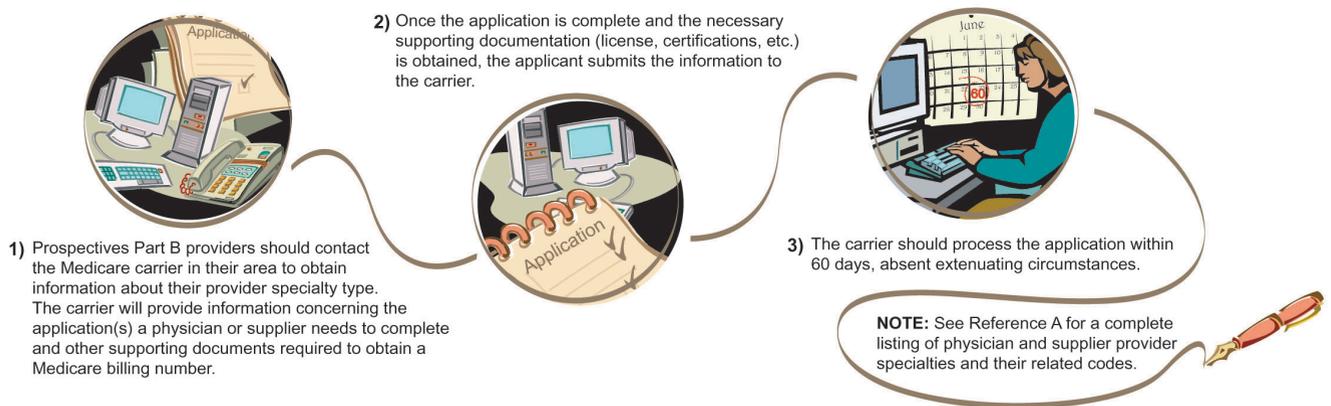
Table 2-1. Provider Enrollment Contacts and Survey Requirements

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Ambulance Service Supplier	Carrier	To be determined by carrier (TBD)	Not Applicable (N/A)	N/A
Ambulatory Surgical Center (ASC)	Carrier	CMS-855B	State Agency	Accredited by CMS-approved organization, or surveyed by State Agency
Audiologist	Carrier	TBD	N/A	N/A
Certified Clinical Nurse Specialist	Carrier	TBD	N/A	N/A
Certified Nurse Midwife	Carrier	TBD	N/A	N/A
Certified Registered Nurse Anesthetist	Carrier	TBD	N/A	N/A
Clinic/Group Practice	Carrier	TBD	N/A	N/A

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Clinical Psychologist	Carrier	TBD	N/A	N/A
Durable Medical Equipment (DME), Prosthetics, Orthotics, or Supplies	National Supplier Clearinghouse (NSC)	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency CMS-855A
Hospital	Fiscal Intermediary (FI) Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency CMS-855A
Hospital Department Billing for Part B Practitioner Services	Carrier	CMS-855B	N/A	N/A
Independent Clinical Laboratory	Carrier	CMS-855B	State Agency	State Determines
Independent Diagnostic Testing Facility	Carrier	CMS-855B	N/A	N/A
Indian Health Services Facility	Part A providers - CMS Regional Office (RO) Part B Providers - carriers (TrailBlazer)	TBD by carrier <u>OR</u> RO	Part A Providers - State Agency	Part A Providers State Determines
Mammography Screening Center	Carrier	TBD	N/A	N/A
Managed Care Organization	Carrier	TBD	N/A	N/A
Mass Immunization Roster Biller	Carrier	TBD	N/A	N/A
Medical Faculty Practice Plan	Carrier	TBD	N/A	N/A
Multi-Specialty Clinic or Group Practice	Carrier	TBD	N/A	N/A

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Nurse Practitioner	Carrier	TBD	N/A	N/A
Occupational Therapist in Private Practice	Carrier	TBD	N/A	N/A
Occupational Therapy (OT) (Group)	Carrier	TBD	N/A	N/A
Other Medical Care Group	Carrier	TBD	N/A	N/A
Pharmacies	NSC	TBD	N/A	N/A
Physical Therapist in Private Practice	Carrier	TBD	N/A	N/A
Physical Therapy (PT) (Group)	Carrier	TBD	N/A	N/A
Physiotherapy	Carrier	TBD	N/A	N/A
Physician's Assistant (PA)	Carrier	TBD	N/A	N/A
Physician	Carrier	TBD	N/A	N/A
Portable X-ray Facility	Carrier	CMS-855B	State Agency	State Agency
Psychiatric Unit (of a Hospital)	FI Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Registered Dietitian/Nutrition Professional	Carrier	TBD	N/A	N/A
Rehabilitation Unit (of a Hospital)	FI Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Rural Health Clinic	Regional Rural Health Clinic Intermediary Also carrier if operating as a group practice	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Voluntary Health/ Charitable Agency	Carrier	TBD	N/A	N/A

Figure 2-1. Medicare Enrollment Process



When Part B providers (physicians or suppliers) enroll in Medicare, the enrollment process generally proceeds as shown in Figure 2-1.

If a physician or supplier already submitted an application, and has a problem with the carrier, they should contact the CMS RO. The RO is responsible for monitoring the carrier's performance and assisting the applicant. For additional information regarding the RO, refer to Part I, Where is CMS Located?



Enrolling or Updating Enrollment Status
 Each provider/supplier setting has very specific instructions for enrollment and for changing enrollment status. Detailed information can be accessed at <http://www.cms.hhs.gov/Providers/enrollment/> on the Web.

MEDICARE PROVIDER ENROLLMENT FORMS

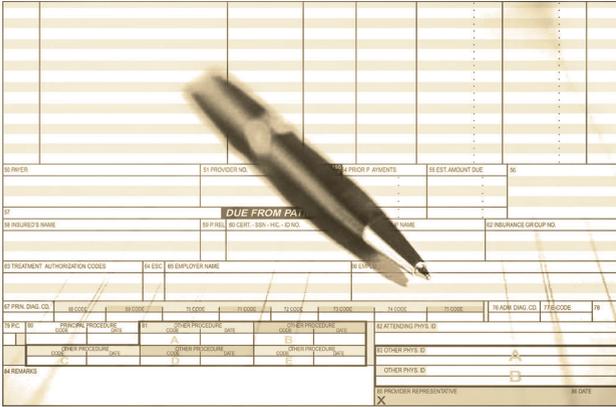
As mentioned previously, Medicare requires physicians and suppliers to submit specific forms to enroll or update enrollment status. Previously, all Part A and Part B providers completed a lengthy and complex Form CMS-855. Since the type of information required for enrollment/updates varies by the type of provider, CMS created the following five different versions

of Form CMS-855 for enrollment that are easier for providers to complete:

- ❖ **Form CMS-855A** - Healthcare providers who will bill Medicare FIs;
- ❖ **Form CMS-855B** - Healthcare providers who will bill Medicare carriers;
- ❖ **Form CMS-855I** - Individual Healthcare Practitioners (e.g., physicians and non-physician clinicians billing Medicare directly);
- ❖ **Form CMS-855R** - Individual Reassignment of Benefits (e.g. physicians and non-physician practitioners that assign their payments to a group practice); and
- ❖ **Form CMS-855S** - DME suppliers.

These Form CMS-855s are available in both electronic format (which is interactive) and Portable Data Format (PDF) to download. The electronic version is compatible with Windows 95 or above. The electronic format will allow providers and suppliers to complete the forms and save information for future use (e.g., if they must report changes). It will provide real-time edit checks and instructions for completing the form. These forms cannot be submitted electronically, but must be printed and submitted in hardcopy format. The **form must be signed and dated**, and mailed to the contractor for the provider's locality (see Figure 2-2).

Figure 2-2. CMS Forms **MUST** be Signed and Dated.



COMMON PROVIDER ENROLLMENT FORMS

Listed below are common questions asked by physicians or suppliers when enrolling in the Medicare Program.

Who is the authorized representative?

The authorized representative must be an officer, chief executive officer (CEO), or general partner of the organization. This individual is a person to whom the enrolling organization has granted the legal authority to:

- ❖ Enroll the organization in the Medicare Program;
- ❖ Make changes and/or updates to the organization's status in the Medicare Program (e.g., adding new practice locations, changing the organization's address, etc.); and
- ❖ Commit the organization to the laws and regulations of Medicare.

What is the effective date of enrollment in Medicare?

This date varies by provider type. The enrollee should contact his or her local carrier or the NSC for more information.

How long does the enrollment process typically take?

For most applicants, the application process will take 60 days. CMS requires its contractors to process 90% of applications within 60 calendar days of receipt or earlier, and process 99% of applications within 120 calendar days of receipt. If the applicant has not submitted all the necessary accompanying documentation, or the contractor has to request additional information, the contractor will contact the applicant initially by telephone to expedite the collection of any missing or additional information.

For certain types of providers (e.g., those that require state surveys or accreditation), it will take longer to become enrolled.



Determining Local Contractors

An applicant can determine the current contractor for a particular locality at <http://www.cms.hhs.gov/Providers/enrollment/contacts/> on the Web.

The following additional forms are often required in addition to Form CMS-855s to help facilitate physician and supplier payments:

- ❖ **Form CMS 588** - Medicare authorization agreement for electronic funds transfers;
- ❖ **Form CMS 460** - Medicare Participating Physician or Supplier Agreement; and
- ❖ **Electronic Data Interchange (EDI) Agreement.**



CMS Forms and Instructions for Completion

All of the various CMS forms and user guidance for completing these forms are available at <http://www.cms.hhs.gov/Providers/enrollment/forms/> on the Web.

If a physician or supplier has any questions regarding the proper completion of any of these forms, he or she should contact his or her appropriate Medicare payment contractor (carrier or DMERC) for assistance.

How does a provider make changes to the information on file with Form CMS-855?

Changes should be reported within 90 days of the change using the appropriate Form CMS-855, based on the physician or supplier type. Providers must complete only the first section of the form and any sections that reflect the changes, additions, or deletions being made, and then sign the certification statement.

If physicians or suppliers need to report changes to enrollment information and have not previously completed a Form CMS-855, they can still use the forms to make changes to the information. However, physicians and suppliers must furnish enough information on Form CMS-855 for the carrier or NSC to make the changes.

Is a photocopy of Form CMS-855 acceptable?

A photocopy of Form CMS-855 is acceptable. However, the signature must be original. Stamped, faxed, or copied signatures are **NOT** acceptable. Although the form may be photocopied **AFTER** it has been signed, it is unlawful to alter it in any manner once it has been signed.

Who needs a surety bond prior to participating in the Medicare Program?

Currently, neither providers nor suppliers are required to obtain surety bonds to participate in the Medicare Program.

What officials in a non-profit organization must be reported on Form CMS-855?

Managing/Directing Employees

Most non-profit organizations are run by a governing board (e.g., Board of Directors). As such, each member of the applicable governing board should be reported in the Managing/Directing Employees section of Form CMS-855.

Owners

Although the vast majority of non-profit organizations do not have owners, any individual



who owns at least 5% of the non-profit organization must be reported in the Owner Information section of Form CMS-855. If a non-profit organization has a unique organizational structure, the organization must contact their carrier or NSC for more information.

Who does Medicare recognize as a physician?

The Medicare Program defines a physician as a doctor of medicine or osteopathy (M.D. or D.O); a doctor of dental surgery or dental medicine; a chiropractor; a doctor of podiatry or surgical chiropody; or a doctor of optometry, legally authorized to practice by a state in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.

The issuance by a state for a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local

standards are used in determining whether a particular physician has legal authorization. If the state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Does Medicare recognize medical residents and interns for payment purposes?

For Medicare purposes, the terms “interns” and “residents” include physicians participating in approved post-graduate training programs and those who are not in approved programs, but who are authorized to practice only in a hospital setting. These include, for example, individuals with temporary or restricted licenses and graduates of foreign medical schools who do not have a valid medical license. The status of a senior resident who has a staff or faculty appointment or is designated (e.g., a fellow) does not change for the purposes of Medicare coverage and reimbursement.

Generally, the FI pays services of interns and residents as physician services. Except for services furnished by interns and residents outside the scope of his or her training program, the following types of services performed by interns and residents are reimbursable to the hospital under Part B, on a reasonable cost basis:

- ❖ Services by interns and residents not in approved training programs; and
- ❖ Services performed for hospital outpatients.



Intern and Resident Services Information

The *Medicare Resident & New Physician Training Guide* provides additional details regarding intern and resident services furnished either under an approved training program, or outside an approved training program. The publication may be accessed and downloaded at <http://www.cms.hhs.gov/physicians/> on the Web.

How does Medicare recognize non-physician practitioners for payment purposes?

Medicare allows payment for services furnished by non-physician practitioners. These include but are not limited to:

- ❖ Advanced registered nurse practitioners (ARNPs);
- ❖ Clinical nurse specialists (CNSs);
- ❖ Licensed clinical social workers (LCSWs); and
- ❖ Physician assistants (PAs).

To submit claims to Medicare for reimbursement, a non-physician practitioner must first apply to the program by completing Form CMS-855I and submitting the required documentation. If the application is approved, payment is allowed for the practitioner's services in all areas and settings permitted under applicable state licensure laws.



Payment to Non-Physician Practitioners

No separate payment may be made to the non-physician practitioner if a facility or other physician payment is also made for such professional service.

When an ARNP or PA renders services that are integral, but incidental to a physician's service (i.e., “incident to” services), the physician's provider number should be submitted on the claim. In this situation, a provider number for the ARNP or PA is not needed. For more information, refer to the “Incident to” Policies of the carrier.

How is supplier enrollment and claims processing different than other Part B providers?

Instead of enrolling with a local carrier, DME suppliers should submit a Form CMS-855S to the National Supplier Clearinghouse (NSC) at:

P.O. Box 100142
Columbia, SC 29202-3142

Claims for supplies, orthotics, prosthetics, equipment and certain injectables are submitted to the DMERC. The beneficiary's home state determines which DMERC is responsible for processing his or her claim. To determine the appropriate DMERC, providers should contact their local carrier.



List of Available Carriers

A list of carriers is available at <http://www.cms.hhs.gov/Providers/enrollment/contacts/> on the Web.

What does “physician/supplier specialty” mean?

Medicare Part B enrolls physicians/suppliers based on their credentials or specialties. Medicare recognizes many specialties (see Reference A for a list of provider specialties and their related codes). Physicians may have a primary specialty and a sub-specialty. Since a physician's specialty may be used to determine peer utilization review comparisons, physicians should notify the carrier of their practice's *predominant* specialty for annotation within Medicare records. No payment differential is applied to a service based on a physician's specialty. However, some non-physician/supplier specialties (e.g., PA) have a payment differential.

What is the difference between a PIN and a UPIN?

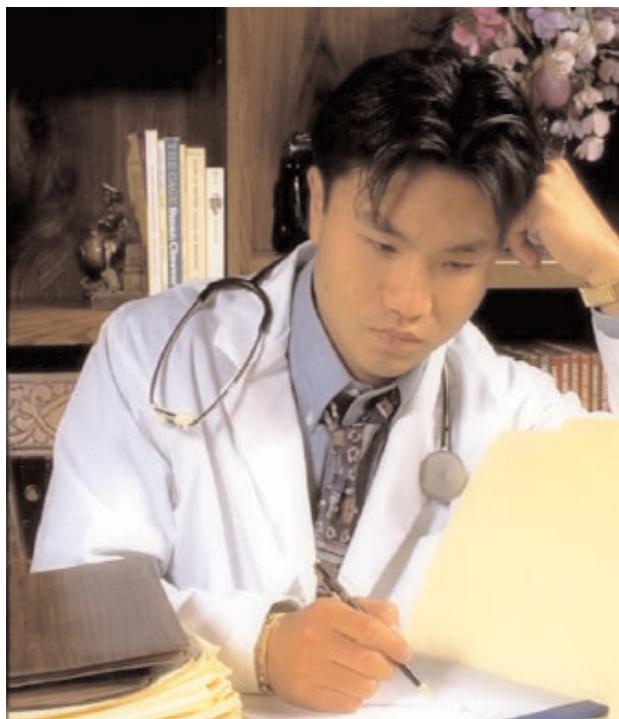
Physicians receive and must use the following identifying numbers:

- ❖ **Provider Identification Number (PIN)** - used as a provider billing number to receive reimbursement.
- ❖ **Unique Physician/Practitioner Identification Number (UPIN)** - used only when a service requires a referring or ordering physician. This number is never used as a provider billing number.

Part B providers are assigned a PIN by their carrier. The PIN identifies the facility or individual that provided the beneficiary's service and allows the provider or patient to receive reimbursement for claims filed to the Medicare payment contractor. The PIN format is unique and varies between FIs and carriers. All Medicare claims filed to payment contractors require a PIN; if a provider fails to show a PIN in the appropriate paper claim block or electronic claim field, the claim will be denied as “unprocessable”.

The UPIN is assigned by CMS. It is a six-character alphanumeric code used to identify the Medicare provider. This number is assigned to physicians, non-physician practitioners, groups/clinics, and suppliers (excluding those billing to the DMERC) to identify the referring or ordering physician on a Medicare claim.

Each individual practitioner (physicians and non-physician practitioners only) receives one UPIN, regardless of the number of practice settings. The individual practitioner keeps the UPIN throughout his or her Medicare affiliation, regardless of the state in which he or she practices. CMS uses the UPIN to identify the ordering and referring physician, to aggregate



UPIN Requirements

A UPIN is required if the service is requested by:

- ❖ A referring physician who requests an item or service for a beneficiary, for which payment may be made under the Medicare Program; or
- ❖ An ordering physician who orders non-physician services for a beneficiary, such as diagnostic laboratory tests, clinical laboratory tests, or DME.

The UPIN requirement is based on the type of service, not the physician's specialty. Services currently include:

- ❖ Consultation services;
- ❖ Routine foot care;
- ❖ DME and other medical supplies;
- ❖ Orthotics/prosthetic devices, including optical supplies;
- ❖ Most diagnostic services, including laboratory and radiology services; and
- ❖ Services by independently-practicing physical or occupational therapists.

Surrogate UPINs

A surrogate UPIN is used temporarily if a UPIN has been requested, but has not yet been assigned to the ordering/referring physician. A surrogate UPIN contains three alpha characters followed by three zeros. All surrogate UPINs, except those of retired physicians (RET000), may be used only until an individual UPIN is assigned. Carriers monitor all surrogate UPINs for misuse. Surrogate UPINs require the physician's name and address. Ordering/referring physicians who may require a surrogate UPIN include:

- ❖ RES000 - intern, resident, and fellow;
- ❖ VAD000 - active U.S. military physicians and those employed by the Department of Veterans Affairs;

- ❖ PHS000 - Public Health Service physicians (including the Indian Health Service);
- ❖ RET000 - retired physician (Retired physicians must use their assigned UPIN); and
- ❖ OTH000 - when the ordering/referring physician has not received a UPIN and does not meet the criteria for one of the other surrogate UPINs; used until an individual UPIN is assigned.

When services requiring a UPIN are performed and no referring physician exists, the UPIN and name of the performing physician must be reported.

payment and utilization information for individual practitioners, to ensure compliance with contractor recommendations for sanctions, and to validate duplicate services.

What is an individual healthcare practitioner?

Individual healthcare practitioners are physicians and non-physician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered. These practitioners must complete Form CMS-855I.

Those individual healthcare practitioners who directly bill the Medicare carrier for their services will be issued their own individual PIN. The address tied to the PIN is usually the provider's billing/mailling address, which may differ from the physical address where medical services are rendered. Often, providers do not want checks coming to their physical addresses. Many carriers can maintain two addresses in the provider's address file. Medicare may verify a new provider's address by contacting the post office, by a personal visit, or by other means.

Can an individual healthcare practitioner have multiple Medicare numbers for different practice locations?

The carrier may issue more than one PIN depending upon the physician fee localities

(geographic regions) in which a provider's practices are located. The local Medicare carrier will determine whether more than one billing number will be issued. Individuals furnishing services in multiple offices should contact their local carrier to determine if more than one number will be issued.

What is a physician-directed group/clinic practice?

A physician-directed group/clinic may be a partnership, association, or corporation composed of physicians or non-physician practitioners who wish to bill Medicare as a unit. The group must complete Form CMS-855B.

If a physician wishes to file claims as part of a group/clinic, the group/clinic must request a group/clinic PIN number for billing purposes. Each local carrier issues its own group/clinic PINs, so number formats will vary by carrier. The group/clinic PIN makes the group unique when filing services to the local carrier.

The address tied to the PIN is usually the group/clinic's billing or mailing address, which may differ from its physical address. Often, group/clinics do not want checks coming to their physical addresses. Many carriers can maintain two addresses in the provider's address file. Medicare may verify a new group's address by contacting the post office, by a personal visit, or by other means.

How do individual healthcare practitioners join or leave a group?

If both the individual healthcare practitioner and the group are already enrolled with the carrier, the individual **AND** the group together are required to complete Form CMS-855R showing the date the individual joined the group and reassigned benefits to the group. If an individual leaves a group, the individual **OR** the group should complete Form CMS-855R, showing the date the individual left the group. There is no need for Form CMS-855R to be signed by both the individual and the group; one form will suffice.

If either the individual or the group has not enrolled with the carrier, he or she or the group must first complete the appropriate Form CMS-855 for either an individual (Form CMS-855I) or group (Form CMS-855B) number before the reassignment can be effective.

What does "reassignment of benefit" mean?

Each member within the group/clinic must complete an Individual Reassignment of Benefits Form (Form CMS-855R) stating that they agree to turn all monies over to the group/clinic. After the reassignment agreement has been signed, the local Medicare carrier will tie the individual physician's PIN to the group/clinic PIN. When the group/clinic bills Medicare, they must use this provider number when filing for services performed as part of the group.

What is a "participating provider" and how does a Part B provider become one?

The term "participating provider" has the different meanings for each of the different provider types.

For physicians and suppliers, such as suppliers of DME, prosthetics, orthotics, or supplies, the term means that the Part B provider will always accept assignment on claims submitted on behalf of a Medicare beneficiary. When such a Part B provider accepts assignment, the Part B provider agrees to bill the beneficiary only for any coinsurance or deductible that may be applicable, and accepts the Medicare payment as full payment.

Part B providers generally have the option of "participating" in this regard. If a provider chooses not to participate, the provider may still bill Medicare if enrolled in the Medicare Program, but may decide on a claim-by-claim basis whether to accept assignment. However, some Part B provider specialties must always accept assignment if enrolled.

Providers who provide services under the Medicare program are required to accept assignment for all Medicare claims for the services provided. This means that the provider

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% coinsurance.

Assignment is mandated for the following claims:

- ❖ Clinical diagnostic laboratory services and physician laboratory 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, or medical nutritional therapists;
- ❖ Ambulatory surgical center services;
- ❖ Home dialysis supplies and equipment paid under Method II;
- ❖ Drugs; and
- ❖ Ambulance services.

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.

HOW CAN A PART B PROVIDER SEEK MEDICARE REIMBURSEMENT

The Medicare Program is composed of complex reimbursement systems. These systems are designed to provide necessary healthcare services to eligible beneficiaries in a manner that furnishes provider payments that reflect the actual costs of furnishing such care.

When Medicare was implemented in 1966, Medicare was a fee-for-service insurance plan. Part B providers were paid on a reasonable charge basis for most services furnished in a private office or in a Part A provider facility [e.g., Skilled Nursing Facility (SNF)]. As a result of the inflation of Medicare costs in the 1980s and 1990s, Congress mandated several changes to the Medicare reimbursement models that vary depending upon the various provider settings and services furnished.

Today, physicians and suppliers may be reimbursed through private contracts with Medicare managed care plans or through the Original Medicare fee-for-service plans. However, unlike in 1966, most Part B payment methodologies today are based upon Federally-established predetermined payments per procedure or item, rather than on cost or charges. In addition, some supplies and services can no longer be billed to a carrier if a beneficiary

Deciding Whether to Participate

Physicians, practitioners, and suppliers have only one opportunity each year to change participation status for the following calendar year (CY). This is during the carrier open enrollment period, usually in November. Each active Medicare provider receives a participation package during the open enrollment period. This package normally contains information about:

- ❖ Advantages of participating;
- ❖ Medicare Physician Fee Schedule (MPFS) allowances for the next CY;
- ❖ Proposed legislative changes that could impact the participation decision;
- ❖ Provider's current participation status and year of practice for new providers (if applicable); and
- ❖ Participating Physician or Supplier Agreement Form (which need not be completed or returned to Medicare if there is no change in participation status for the following year).

Changing Participation Status

The participation period is one year (from January 1st to December 31st). Once a provider signs a participation agreement, Medicare rarely honors a decision to change participation status during the year. However, a provider wishing to change participation status during the year must notify the local carrier's provider enrollment department and state the reason for the change. The carrier will then consider the request. A participating provider who wishes to continue participating need not sign another participation agreement. The current agreement will remain in effect until the provider notifies the carrier otherwise.

Benefits of Participation

Benefits of becoming a participating provider include the following:

- ❖ **Eligibility Access:** A participating provider submitting electronic media claims (EMCs) may access beneficiary eligibility files via vendor access (see Part 3, How EMC Submission Works, for more information);
- ❖ **Financial:** Medicare Fee Schedule allowances are about 5% higher for participating physicians. In addition, physicians who participate are not subject to limits on actual charges;
- ❖ **Medigap:** Claims with Medigap information will automatically crossover to the beneficiary's supplemental insurer; and
- ❖ **The Medicare Participating Physicians and Suppliers Directory (MEDPARD):** The MEDPARD contains a listing of all participating providers. Carriers maintain a toll-free telephone line that allows Medicare beneficiaries to request information about local participating providers. Some carriers also maintain MEDPARD on their website. Beneficiaries may also access

MEDPARD at <http://www.medicare.gov> on the Web where more detailed physician and supplier information is available, including maps and directions to participating providers.

Note: The directory located at <http://www.medicare.gov> on the Web provides an opportunity for physicians to submit updated information through an online feedback tool.

The local carrier can furnish providers with information about the participation program.

The Non-Participating Provider:

- ❖ Is held to a limiting charge when submitting nonassigned claims;
- ❖ Must file all Medicare claims for potentially reimbursable services on behalf of his or her Medicare patients;
- ❖ May collect up to the limiting charge at the time the services are rendered; and
- ❖ Is reimbursed a Medicare Fee Schedule allowance 5% lower than that of a participating provider.

Note: Pharmaceuticals, equipment, and supplies **ARE NOT** held to a limiting charge when submitting non-assigned claims.

is concurrently receiving Part A services from a SNF or home health agency (HHA).

The following section summarizes some of the key current Medicare reimbursement systems and concepts that may impact Part B providers.

MEDICARE PART B REIMBURSEMENT

Medicare Part B claim reimbursement is generally based on an established "fee-for-service" schedule for claims submitted by Part B physicians and suppliers. After deductibles, most Part B providers are reimbursed at 80% of the lower of either the established Fee Schedule,

reasonable or customary (depending on the type of physician) charge, or their billed charge for the following services:

- ❖ Physician services;
- ❖ Ambulance transportation;
- ❖ DME; and
- ❖ Diagnostic tests.

Some services are reimbursed at 100% of the lower of either the established Fee Schedule or their billed charge. These services include:

- ❖ Clinical laboratory tests;
- ❖ Influenza or pneumococcal vaccinations; and
- ❖ Other exceptions, as defined by CMS.

MEDICARE PART B PHYSICIAN FEE SCHEDULE

With few exceptions, Part B services are paid through a fixed Fee Schedule. These charges are based on three key Resource-Based Relative Value Units (RBRVUs). The RBRVU system fixes a national value for each procedure code, based on the sum of the RBRVUs associated with:

- ❖ The clinician's time, intensity, and technical skill required to render a service;
- ❖ The practice's overhead expenses, such as rent, office staff salaries, and office supplies; and
- ❖ Malpractice insurance premiums.

RBRVUs are established locally to allow for variations in practice costs among geographic areas, and each pricing locality for a given state has a Geographic Practice Cost Index (GPCI) for each RBRVU.

Physician Fee Schedules for all Medicare Part B providers are calculated using one national Conversion Factor (CF). Congress determines the CF each year, considering the projected inflation rate, projected versus actual claims volumes, Medicare enrollment changes, and other factors potentially impacting the Medicare Part B budget. Carriers and DMERCs may only

establish local pricing for procedures that do not have an established national rate. The Fee Schedule is updated annually on January 1. Part B providers are furnished their local Fee Schedule by their applicable carrier or DMERC.

NON-FACILITY VERSUS FACILITY FEE SCHEDULE ADJUSTMENTS

Certain Part B services primarily performed in individual Part B provider's office settings are subject to a payment limit if performed in:

- ❖ An inpatient or outpatient hospital setting;
- ❖ A hospital emergency room;
- ❖ An SNF;
- ❖ A comprehensive inpatient or outpatient rehabilitation facility;
- ❖ An inpatient psychiatric facility; or
- ❖ An Ambulatory Surgical Center (ASC).

Medicare pays less because the physician's overhead and other related expenses are lower than they would have been in a standard office setting. Physicians are not allowed to bill the beneficiary for the difference between the actual charges and the reduced allowed amount based on the location of the service provided. If physician services are not provided in a standard office setting, the allowed amount will be the lower value of either the actual charge or the reduced Fee Schedule amount. Carriers are required to publish facility fee pricing schedules. This adjustment does not apply to outpatient rehabilitation services (physical therapy, occupational therapy, or speech-language pathology services) furnished in the mentioned facilities. Further payments would remain at the higher non-facility rate.

MEDICARE PART A REIMBURSEMENT

Although physicians and suppliers are not reimbursed by the Part A benefit, several Part A payment policies can influence payments to some physician and suppliers. Today, most Part A providers such as hospitals, SNFs, and home health agencies receive payments through a Prospective Payment System (PPS) designed to cover the costs of all items and services



CMS Fee Schedule Lookup Resource

Billers who may be processing claims or claim denials can access the MPFS lookup resource at <http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp> on the Web.

This website is designed to provide information on services covered by the MPFS. It provides more than 10,000 physician services, the associated relative value units, a Fee Schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The MPFS pricing amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPICs are applied in the calculation of a Fee Schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

The site allows providers to:

- ❖ Search pricing amounts, various payment policy indicators, RVUs, and GPICs by a single procedure code, a range, and a list of procedure codes for the previous four years.
- ❖ Search for the nation, a specific carrier, or a specific carrier locality. Each page has associated Help/Hint available to complete the selections.

furnished to beneficiaries while they are under the care of that facility.

In other words, many items and services that previously were billable to carriers are now covered under "Consolidated Billing" provisions

of the Part A PPS system. This means that many items (e.g., DME) and services (e.g., physical therapy services) must be billed to the FI by the facility, even if they were furnished by a Part B provider under arrangement.

Physicians and suppliers who attempt to bill carriers for such items and services will have their claims rejected. Part B providers should contact their local carrier to learn what "Consolidated Billing" provisions may apply to their provider type or services they furnish. Physicians and suppliers that furnish Medicare covered services to beneficiaries for which the "Consolidated Billing" provisions apply need to make arrangements with the hospital, SNF, or HHA receiving Part A payments to seek reimbursement.

MEDICARE MANAGED CARE REIMBURSEMENT

A *capitation rate* is a fixed amount that CMS pays to a managed care plan selected by an enrolled Medicare beneficiary. CMS pays the plan, which then reimburses the provider for services provided within the terms of the agreement/plan, regardless of the cost or amount of care provided to each Medicare beneficiary enrolled in the managed care plan.

Enrollment as a Part B provider does not ensure payment from a Medicare managed care plan. Provider reimbursement in a Medicare managed care plan is based solely upon the terms of the provider's agreement with the plan, regardless how Medicare pays for Part B services.

NOTES