





## Announcement

### About Medicare Participation for Calendar Year 2008

Medicare continues to ensure that payment policies provide incentives to improve the quality of care. The Centers for Medicare & Medicaid Services (CMS) is building on changes established last year to pay more appropriately for practice expenses and to transform Medicare into an active purchaser of high quality services.

In 2008, we will make a number of changes to payments for specific services paid under the physician fee schedule, including increasing the work component of anesthesia services by 32 percent. We will also include new quality measures that were developed with input from the American Medical Association (AMA) Physician Consortium for Performance Improvement (physician measures), the Pennsylvania Quality Improvement Organization (QIO) (non-physician and structural measures), and the American Podiatric Medical Association. As required by the sustainable growth rate (SGR) formula specified in the Medicare statute, the estimated update to the physician fee schedule for 2008 is negative 9.9 percent. The negative update is required by law for 2008 because spending on physicians' services and other Part B services has been growing at a much faster rate than target spending.

Physician groups have been working hard to identify better ways for Medicare to pay – ways that better support physician efforts to provide higher-quality care without increasing overall health care costs. CMS will continue to work with Congress and with physician groups on a system that will provide predictable and stable payments that will ensure higher quality care for beneficiaries without increasing Medicare spending.

All physicians, practitioners and suppliers must make their calendar year (CY) 2008 Medicare participation decision by December 31, 2007. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2008. The majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2007, 93.3 percent of all physicians, practitioners and suppliers are billing under Medicare participation agreements.

#### WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who assign both their Medicare and Medigap payments to participants. 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.

### WHAT TO DO

If you choose to be a participant in CY 2008:

- 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 2008:

- 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, 2008. This written notice must be postmarked prior to January 1, 2008.

Hold onto this announcement during this enrollment period. You may want to refer to it again before making your decision regarding Medicare participation for CY 2008.

We hope you will decide to be a Medicare participant in CY 2008.

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

**To view updates and the latest information about Medicare, or to obtain telephone numbers of the various carrier contacts including the carrier medical directors, please visit the CMS web site at <http://www.cms.hhs.gov/>.**

***To view the calendar year 2008 Medicare Physician Fee Schedule and Anesthesia Conversion Factors, please visit your local carrier web site:***

***[www.triples-med.org/webmedicare/noticias\\_y\\_publicaciones/material\\_de\\_referencia/Tarifas/index.htm](http://www.triples-med.org/webmedicare/noticias_y_publicaciones/material_de_referencia/Tarifas/index.htm)***

**For Triple S, Inc. , you may contact the following toll-free number(s) for assistance:  
1-877-715-1921.**



## Anuncio

### Sobre la Participación en Medicare durante el Año Calendario 2008

Medicare continúa asegurándose de que las políticas de pago proveen incentivos para mejorar la calidad del cuidado de la salud. Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) está edificando sobre los cambios establecidos el año pasado para pagar más apropiadamente por los costos de práctica y para transformar a Medicare en un comprador activo de servicios de alta calidad.

En el 2008 llevaremos a cabo unos cambios a los pagos de servicios específicos que se pagan bajo las tarifas fijas de Medicare para médicos, incluyendo aumentar 32 por ciento el componente de trabajo de los servicios de anestesia. También incluiremos nuevas medidas de calidad que se desarrollaron con información del **American Medical Association (AMA) Physician Consortium for Performance Improvement** (medidas para médicos), del **Pennsylvania Quality Improvement Organization (QIO)** (medidas estructurales y no médicas), y del **American Podiatric Medical Association**. La actualización estimada a las tarifas fijas de los médicos para el 2008 es negativo 9.9 por ciento, como lo requiere la razón de crecimiento sostenible (**sustainable growth rate [SGR]**). Esa actualización se requiere por ley para el 2008 porque los gastos en servicios médicos y otros servicios de la Parte B han crecido a una razón más alta de lo apuntado en gastos.

Existen grupos de médicos que han estado trabajando arduamente para identificar mejores formas para pagar; formas que apoyan mejor los esfuerzos de los médicos para proveer un cuidado de la más alta calidad sin incrementar los costos totales del cuidado de la salud. CMS continuará trabajando con el Congreso y con los grupos de médicos en un sistema que proveerá pagos predecibles y estables que asegurarán un cuidado de una calidad más alta para los beneficiarios, sin aumentar los expendios de Medicare.

Todos los médicos, profesionales de la salud y suplidores deberán tomar su decisión de participación en Medicare correspondiente al año calendario 2008, para el 31 de diciembre de 2007. Firmar un acuerdo de participación significa convenir aceptar la asignación para todos los servicios cubiertos que usted le provee a pacientes de Medicare durante el año calendario 2008. La mayoría de los médicos, profesionales de la salud y suplidores han elegido participar en Medicare. Durante el año calendario 2007, el 93.3 por ciento de todos los médicos, profesionales de la salud y suplidores están facturando bajo acuerdos de participación con Medicare.

## ¿POR QUÉ PARTICIPAR?

Si usted factura por servicios profesionales médicos, servicios y suministros provistos incidentales a servicios profesionales médicos, servicios ambulatorios de terapia ocupacional y física, pruebas diagnósticas o servicios radiológicos, las cantidades de las tarifas fijas de Medicare para médicos serán 5% más altas si usted participa. Además, los proveedores reciben sus reembolsos directamente y en un tiempo apropiado de parte de Medicare.

Independientemente de los servicios de la Parte B de Medicare que usted factura, los proveedores participantes de Medicare pueden disfrutar del privilegio de hacer una sola facturación para los beneficiarios que asignan tanto sus pagos de Medicare como los de Medigap a los participantes. Los beneficiarios con cobertura Medigap (seguro complementario privado) pueden asignar el pago de la reclamación complementaria al proveedor o al suplidor. Bajo el proceso mandatario actual de transferencia de reclamaciones Medigap (***claim-based crossover process***) los beneficiarios tienen el deber de asignar el pago de sus reclamaciones a un proveedor o suplidor participante como condición para que sus reclamaciones se les trasfieran a su asegurador Medigap para el pago de todas las cantidades de coaseguros y deducibles pagaderos bajo la póliza de Medigap. A su vez, la aseguradora Medigap debe pagarle al proveedor o suplidor participante directamente, de esa manera se evita la necesidad de tener que someter una segunda reclamación.

## ¿QUÉ HACER?

Si usted opta por ser participante durante el año calendario 2008:

- No haga nada si actualmente es participante, o
- Si actualmente no es participante de Medicare, complete el acuerdo en blanco incluido y envíelo por correo (o una copia de este) a cada contratista a quien usted le somete reclamaciones de la Parte B. (En el formulario indique los nombres y los números de identificación bajo los cuales usted factura.)

Si usted decide no participar durante el año calendario 2008:

- No haga nada si actualmente no es participante, o
- Si actualmente es participante, escríble a cada contratista de la Parte B a quien le somete reclamaciones indicándole su decisión de terminar el acuerdo de asignación vigente el 1 de enero de 2008. Esta notificación por escrito debe tener matasellos del correo con fecha previa al 1 de enero de 2008.

Guarde este anuncio durante este periodo de suscripción. Tal vez querrá referirse a él nuevamente antes de tomar su decisión sobre la participación en el Programa de Medicare para el año calendario 2008.

Esperamos que decida ser participante en Medicare durante el año calendario 2008.

Por favor llámenos si tiene cualquier pregunta o necesita más información sobre la participación.

**Para ver actualizaciones y la información más reciente sobre el Programa de Medicare o para obtener los números telefónicos de varios contactos que incluyen los directores médicos de los contratistas de la Parte B, por favor visite el sitio Web de CMS:**

<http://www.cms.hhs.gov/>

***Para ver las Tarifas Fijas de Medicare para Médicos del año calendario 2008 y los Factores de Conversión para Anestesia, por favor visite el sitio Web de su contratista local de la Parte B:***

[http://www.triples-med.org/webmedicare/noticias\\_y\\_publicaciones/material\\_de\\_referencia/Tarifas.htm](http://www.triples-med.org/webmedicare/noticias_y_publicaciones/material_de_referencia/Tarifas.htm)

**Para Triple-S, Inc., puede llamar al número telefónico libre de cargos  
1-877-715-1921**

MLN Matters Number: SE0730

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

## Key Medicare News for 2008 for Physicians and Other Health Care Professionals

### Provider Types Affected

Physicians and health care professionals and their staff who bill Medicare carriers and/or Medicare Administrative Contractors (MACs)

### Introduction

This Special Edition article is being provided to keep you, the Medicare physician and health care professional, informed about important Medicare initiatives and new Medicare benefits available in Calendar Year (CY) 2008.

As you once again make your decision to enroll in or terminate enrollment in the Medicare participation program, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to review some important news for 2008. CMS believes this information provides significant benefits to providers and their Medicare patients. It encourages providers to enroll or stay in the Medicare participation program in order to take full advantage of the upcoming changes.

### Information You Need to Know

#### ***National Provider Identifier (NPI) - Get it! Share it! Use it!***

Medicare carriers and A/B MACs began transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair that are reported on the claim cannot be found on the Medicare crosswalk. We urge you to pay attention to the reject reports you receive. The reject reports will help you and your staff identify problems that cause claims to reject.

You should also ensure that your Medicare enrollment information is up to date. If you need to submit a completed CMS-855 (Medicare provider enrollment form), remember to list all of the NPIs that will be used in place of legacy identifiers. If you need to apply for an NPI or update your information in the National Plan and

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Provider Enumeration System (NPPES), please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 Other Provider Identifiers, but is being expanded to accept more in the future.) If the information is different between your Medicare enrollment information and your NPPES record, there is a very good chance your claims will reject. NPPES data may be verified at <https://nppes.cms.hhs.gov> on the CMS website. Contact the NPI Enumerator at 1-800-465-3203 if you need assistance in viewing your NPPES record.

A recent MLN Matters article lists the informational edits that preceded the reject report messages and their meanings. Visit <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website to view the article.

Some incorporated physicians and non-physician practitioners have obtained NPIs as follows: an individual (Entity Type 1) NPI for the physician or non-physician practitioner and an organization (Entity Type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare Provider Identification Number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

Note that after May 23, 2008, legacy identifiers will not be permitted on any inbound or outbound transactions. This includes inbound claims, crossover claims, both paper and electronic remittance advices, the 276/277 claims status inquiries/replies, NCPDP claims, and the 270/271 eligibility inquiries/replies. Also, for up-to-date information on the NPI, CMS recommends periodic visits to <http://www.cms.hhs.gov/NationalProvdentStand/> on the CMS website.

### ***Unique Physician Identification Numbers (UPINs)***

CMS discontinued assigning unique physician identification numbers (UPINs) on June 29, 2007, but will maintain its UPIN public "look-up" functionality and Registry website (<http://www.upinregistry.com>) through May 23, 2008.

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### ***Competitive Acquisition Program (CAP) for Part B Drugs***

The Medicare Modernization Act requires CMS to implement a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment system (PPS) basis. This program is an alternative to the average sales price (ASP) methodology for acquiring certain Part B drugs which are administered incident to a physician's services. In it, physicians are given a choice between buying and billing these drugs under the ASP system, or selecting a Medicare-approved CAP vendor that will supply these drugs.

Participation in the CAP is voluntary, and each year Medicare physicians can elect to participate. Those who do participate will obtain drugs through CAP vendors; the vendors will bill Medicare for the administered drug and will bill the beneficiary for any applicable co-insurance or deductible.

All physicians who participated in the CAP in 2007, and wish to participate in 2008, will need to make the 2008 CAP election during the regular fall election period which will run from October 1, 2007, to November 15, 2007.

Participating physicians can sign up to receive CAP updates from the **CMS-CAP-Physicians-L** electronic mailing list at

<http://www.cms.hhs.gov/apps/maillinglists/default.asp?audience=3> on the CMS CAP Information for Physicians webpage

([http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage)).

### ***Physician Quality Reporting Initiative (PQRI)***

The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes a physician quality reporting system. This program, which CMS has named the "Physician Quality Reporting Initiative" (PQRI), was implemented on July 1, 2007, and establishes a financial incentive for eligible professionals who participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services during that same period.

The proposed 2008 PQRI quality measures were published in the Federal Register as a part of the 2008 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The final 2008 PQRI measures will be published in the 2008 MPFS Final Rule and posted at <http://www.cms.hhs.gov/PQRI> on the CMS PQRI website.

For more information about the PQRI and to access important educational tools, go to <http://www.cms.hhs.gov/PQRI> on the CMS website.

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### ***New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing***

Certificates of medical necessity (CMN) provide a mechanism for suppliers of durable medical equipment and medical equipment and supplies to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Durable Medical Equipment Medicare Administrative Contractors (DME MAC) review the documentation that physicians, suppliers, and providers supply on the CMNs and DME Information Forms (DIFs), and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

On April 13, 2007, CMS announced the development of improved CMNs and DIFs that are consistent with current medical practices and that conform to Medicare guidelines. In this improvement process, CMS revised several CMNs, replaced three CMNs with two DIFs, and revised *Medicare Program Integrity Manual*, Chapter 5, Items and Services Having Special DME Review Considerations. Additionally, these new Office of Management and Budget (OMB) approved forms permit the use of a signature and date stamp that resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.

You can learn more about these revised forms by reading MLN Matters article MM5571 (based on CR 5571, the official instruction issued to the DME MAC); available at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5571.pdf>. The new forms are available at

<http://www.cms.hhs.gov/CMSForms/CMSforms/list.asp#TopOfPage> on the CMS website.

### ***Preventive Services***

Medicare, which began covering preventive services in 1981 with the pneumococcal vaccination, now covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided.

These services include:

- The Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare" visit, which now includes coverage of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at-risk beneficiaries (those with a family history of AAA or males age 65 to 75 who have smoked at least 100 cigarettes in their lifetime). It is important to note that in order to receive this AAA ultrasound screening benefit, beneficiaries must be referred by their physician or other

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qualified non-physician practitioner. You can learn more about the IPPE and AAA ultrasound screening by reading MLN Matters article SE0711, which you can find at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0711.pdf> on the CMS website. CMS has also developed a new quick reference information chart entitled "*The ABCs of Providing the Initial Preventive Physical Examination*". This two-sided laminated chart may be used by Medicare fee-for-service physicians and qualified non-physician practitioners as a guide when providing the IPPE. The chart is currently available at [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QRI\\_IPPE001a.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf) on the CMS website.

- Adult Immunization--Influenza Immunization, Pneumococcal Vaccination, Hepatitis B Vaccination;
- Colorectal Cancer Screening;
- Screening Mammography;
- Screening Pap Test and Pelvic Examination;
- Prostate Cancer Screening;
- Cardiovascular Disease Screening;
- Glaucoma Screening;
- Bone Mass Measurement;
- Diabetes Screening, and Self-Management, Medical Nutrition Therapy Services, and Supplies; and
- Smoking and Tobacco-Use Cessation Counseling.

To learn more details about these preventive benefits, see *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* located at

[http://www.cms.hhs.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf) on the CMS website.

CMS has a variety of educational products and resources to help you become familiar with coverage, coding, billing, and reimbursement for all Medicare-covered preventive services, including:

- The MLN Preventive Services Educational Products Web Page, which provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) on the CMS website.

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- The CMS website (<http://www.cms.hhs.gov>) provides information for the individual preventive service covered by Medicare. At the site, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit <http://www.medicare.gov> on the Internet.

### ***Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding***

Section 302(b) of the Medicare Modernization Act, requires Medicare to replace the current durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) payment methodology, for select items in select areas, with a competitive acquisition process to improve the effectiveness of its payment-setting methodology. This new program will establish payment amounts for certain durable medical equipment, enteral nutrition, and off-the-shelf orthotics by replacing the current payment amounts (under Medicare's DMEPOS fee schedule) with payment rates derived from a bidding process.

Suppliers that want to furnish competitively bid items in a competitive bidding area (CBA) will be required to submit bids to furnish those items, and the winning bids will be used to establish a single Medicare payment amount for each item. Contracts will be awarded to a sufficient number of winning bidders in each CBA to ensure access and service to high quality DMEPOS items.

CMS is phasing in this new program. Bidding for the first phase began in 2007 in CBAs within 10 of the largest Metropolitan Statistical Areas (MSAs), excluding New York, Los Angeles, and Chicago. Prices from the first phase of bidding are scheduled to go into effect in 2008. The program will be expanded into 70 additional MSAs in 2009. After 2009, CMS will expand the program to additional areas.

While this program may have no direct impact on most physicians, it might have impact on where your patients receive their DMEPOS. Some suppliers currently serving your patients may not be selected to continue Medicare participation under the new program and your patients may have to go to new suppliers. While this may happen, please be assured that Medicare will continue to meet the same patient needs for DMEPOS as it has prior to the new program. Medicare is just attempting to meet those concerns in a more cost effective manner in order to protect Medicare funding.

You can find more information about the Medicare DMEPOS competitive bidding program at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> on the CMS website.

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## Provider Education Updates

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### *The Medicare Learning Network*

*The Medicare Learning Network (MLN)*, the brand name for official CMS provider educational products, is designed to promote national consistency in Medicare provider information developed for CMS initiatives. The MLN products available on the MLN web page provide easy access to web-based training courses, comprehensive training guides, brochures, fact sheets, CD-ROMs, videos, educational web guides, electronic listservs, and links to other important Medicare Program information. All educational products are available free of charge and can be ordered and/or downloaded from the MLN web page located at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website. Some of the new information for 2007 on the MLN web page follows.

### *Physician Educational Tools*

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals 2<sup>nd</sup> Edition:** Provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (August 2007); Available in downloadable format.
- **Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians:** Contains rural health services information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the Deficit Reduction Act of 2005. The primary audience includes rural health providers, suppliers, and physicians. (February 2007) Available in hard copy, CD Rom, and downloadable formats.
- **Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals:** Offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals. (July 2007) Available in hard copy, CD Rom, and downloadable formats.
- **Companion Facilitator's Guide – To The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals:** Includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program, including instructions for facilitators, a customization guide, two PowerPoint presentations with speaker notes, pre- and post-assessments, master assessment answer keys, and

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evaluation tools. (January 2007) Available in hard copy, CD Rom, and downloadable formats.

- **Physicians' Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services:** Explains how Medicare helps pay for kidney dialysis and kidney transplant services under the fee-for-service program. (June 2007); Available in hard copy and downloadable formats.

### *Other Educational Tools*

- **Medicare Learning Network Guidance Tool:** Now available in CD ROM format and can be ordered through the Medicare Learning Network, product ordering page. This playable CD will streamline your search to find the most relevant and up-to-date links or URLs for national provider educational materials. A tutorial will show you how to use the Guidance Tool to locate a new link (URL), refine your search, view, download and order educational articles, brochures, fact sheets, web-based training courses, worksheets and videos. Additionally, the MLN Guidance Tool will demonstrate by example how to navigate through sections of CMS' Medicare Learning Network. (January 2007) Available in CD ROM format.
- **Medicare Preventive Services Bookmark:** Lists the preventive services and screenings covered by Medicare and provides a message that encourages health care professionals to talk with their Medicare patients about these preventive services and encourage them to take advantage of these potentially life saving benefits. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities, and other appropriate types of provider/supplier events. (January 2007) Available in hard copy and downloadable formats.
- **Quick Reference Information: Medicare Preventive Services:** A two-sided laminated reference chart that gives Medicare fee-for- service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services. (May 2007) Available in hard copy and downloadable formats.
- **Quick Reference Information: Medicare Immunization Billing (Flu, PPV, and HBV):** A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare billing information for the influenza, Pneumococcal, and hepatitis B vaccines and their administration. (October 2006) Available in hardcopy and downloadable formats.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals:** An educational video program that provides an overview of coverage criteria for Medicare preventive benefits. This program can be viewed individually or as part of an

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education session at a conference or other provider meeting. (The program is 75 minutes in length and approved by CMS for continuing education credits for successful completion.)

- **Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart:** Provides Medicare claims processing information related to SNF spells of illness. (January 2007); Available in downloadable format only.

### *Brochures*

**Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs):** Addresses the CMS multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. (May 2007)

**Diabetes-Related Services** – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. (August 2007)

### *Fact Sheets*

- **Critical Access Hospital Program:** Covers information related to the Critical Access Hospital Program. (March 2007)
- **Federally Qualified Health Center Fact Sheet:** Covers the Federally Qualified Health Center (FQHC) benefit under Medicare. (March 2007)
- **Implementation of the UB-04:** Reviews the new UB-04 paper claim form which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk. (May 2007); Available in downloadable format only.
- **Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet** This fact sheet provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion. (March 2007)
- **Medicare Disproportionate Share Hospital Fact Sheet:** Covers the basics of the Medicare Disproportionate Share Hospital (DSH). (August 2007)
- **Medicare Physician Fee Schedule Fact Sheet:** Provides general information about the Medicare Physician Fee Schedule. (January 2007)
- **Medicare Secondary Payer Fact Sheet:** Provides a general overview of the Medicare Secondary Payer provision for individuals involved in the admission and billing procedures at provider, physician and other supplier settings. (June 2007)

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- **Rural Health Clinic Fact Sheet:** Covers the basics of the Rural Health Clinic (RHC) Program. (June 2007)
- **Rural Referral Center Fact Sheet:** Covers the basics of the Rural Referral Center (RRC) Program. (March 2007)

### *Web Based Training Programs*

- **CMS Form 1450:** Provides information that will allow you to file Medicare Part A claims accurately and reduce your chances of receiving unprocessable rejections. (January 2007)
- **CMS Form 1500:** Provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections. (May 2007)
- **Diagnosis Coding: Using the ICD-9-CM:** Teaches you how to select accurate diagnosis codes from the ICD-9-CM volumes and how to use diagnosis codes correctly on Medicare claim forms. (May 2007)
- **Medicare Fraud and Abuse:** Teaches you how to identify Medicare fraud and abuse. You will also learn what safeguards to use to protect yourself against fraud and abuse and what liability and penalties you could face if you commit fraud or abuse. (April 2004)
- **Outpatient Code Editor (OCE):** Useful for physicians and other health care professionals. This course addresses the OCE in Medicare's Fiscal Intermediary Standard System, which processes outpatient claims. (January 2007)
- **Medicare Preventive Services Series: Part 1 Adult Immunizations:** This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration. (Updated September 2007)

### *National Provider Identifier*

- **Health Care Providers - Who are Sole Proprietors?:** A sole proprietor/sole proprietorship is an individual and, as such, is eligible for a single NPI. Read more about Sole Proprietors and the NPI. (July 2007)
- **Health Care Providers - Who are Organizations?:** Organization health care providers apply for NPIs as Organizations (Entity Type 2). Read more about Organization Providers and the NPI. (July 2007)
- **Tip Sheets -What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers:** interprets

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the recently released contingency guidance into helpful steps for providers. (May 2007)

- **National Provider Identifier Training Package:** CMS has developed a Training package for NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each Module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand alone or can be combined with other Modules for a training session tailored to the particular audience.
- **Enrolling in Medicare:** CMS has posted a document that will assist physicians in completing the CMS-855I, Medicare Provider Enrollment Application for Physicians and Non-Physician Practitioners. The document is available at <http://www.cms.hhs.gov/Medicareprovidersupenroll/downloads/Enrollme ntNPI.pdf> on the CMS website.

#### ***Physician Quality Reporting Initiative (PQRI) Tool Kit***

CMS has developed a "PQRI Tool Kit ~ Six Steps for Success" that will assist eligible professionals with successful reporting, as well as education of staff. This Tool Kit is also useful for group presentations and training programs. Currently, the Tool Kit consists of six educational resources (listed below). Each resource in the Tool Kit is designed to stand alone or can be combined with other resource for a training session tailored to the particular audience. The Tool Kit includes:

- **2007 PQRI Physician Quality Measures** - A numerical listing of all measures included in 2007 PQRI;
- **MLN Matters Article 5640- Coding & Reporting Principles** - A publication that introduces the coding and reporting principles underlying successful PQRI reporting;
- **2007 PQRI Code Master** - A numerical listing of all codes included in PQRI intended for incorporation into billing software;
- **2007 Coding for Quality Handbook** - A handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios;
- **2007 Data Collection Worksheets** - Measure-specific worksheets that walk the user step-by-step through reporting for each quality measure; and

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- **2007 PQRI Measure Finder Tool and User Guide** - A tool designed to assist eligible professionals and their practice staff to quickly search for applicable measures and their detailed specifications.

### ***Physician Quality Reporting Initiative (PQRI) PowerPoint Presentations***

CMS has developed PowerPoint presentation modules that will assist eligible professionals with successful reporting, as well as education of staff. These PowerPoint presentation modules are also useful for group presentations and training programs.

## **Beneficiary Related News**

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### ***MyMedicare.com***

As announced in last year's article, Medicare beneficiaries can access Medicare's free secure online service to view their Medicare information by registering for MyMedicare.com. At this site, they can access their personalized information about their Medicare benefits and services, and can:

- View claim status (excluding Part D claims);
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card;
- View eligibility, entitlement, and preventive services information;
- View enrollment information including prescription drug plans;
- View or modify their drug list and pharmacy information;
- View address of record with Medicare and Part B deductible status; and
- Access online forms, publications, and messages sent by CMS.

Registration is simple. Medicare beneficiaries should go to <http://www.medicare.gov> and click on the box in the upper left of the screen to sign up for MyMedicare.gov.

## **Additional Information**

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If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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**News Flash** - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at <http://www.cms.hhs.gov/MLNProducts> on the CMS website.

MLN Matters Number: SE0744

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

## IMPORTANT NPI AND ENROLLMENT INFORMATION FOR PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

### Provider Types Affected

Physicians and other practitioners who submit Medicare fee-for-service (FFS) claims to Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs).

### Provider Action Needed



#### STOP – Impact to You

By October 31, 2007, a Medicare system, known as the National Provider Identifier (NPI) Crosswalk, will validate your claims if they contain a legacy number, such as a Medicare Provider Identification Number (PIN), and a NPI. If the NPI/PIN combination in your claim does not match an NPI/PIN combination in the NPI crosswalk, your claim will reject.



#### CAUTION – What You Need to Know

The Medicare NPI crosswalk contains legacy numbers, which you identified to the National Plan and Provider Enumeration System (NPPES) as part of the process in obtaining your NPI.



#### GO – What You Need to Do

Be sure you supplied the correct information to the NPPES and be sure your billing staff submit the correct NPI/PIN number combination when

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both a legacy number and NPI are submitted on a claim. Your NPI must be compatible with the PIN you received upon Medicare enrollment.

## Background

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By October 31, 2007, all Medicare carriers (and A/B MACs that service providers who formerly billed carriers) will be rejecting Part B claims if they are unable to “match” a NPI and a PIN combination submitted on a claim to an NPI/PIN combination in the Medicare NPI crosswalk. The NPI/PIN combination may be used to identify the Billing, Pay-to, or Rendering Provider (the Pay-to Provider is identified only if it is different from the Billing Provider). This applies to claims that are submitted by corporations that physicians and non-physician practitioners have formed, or by physicians and non-physician practitioners who bill Medicare directly. In this article, we refer to these physicians and non-physician practitioners as “physicians/practitioners.”

### ***Past Medicare Enrollment Practices May Have Contributed to the Use of Incompatible NPI/PIN Combinations***

One reason a claim will reject is if the NPI and PIN used in combination on the claim does not identify the same entity. For example, the NPI in the “Billing Provider” field might be the *corporation's* NPI, but the PIN used in combination with it might be the *physician/practitioner's* PIN. This pairing may be the result of variations in past Medicare enrollment and PIN assignment procedures. For example, Medicare carriers may have combined the enrollment of a physician/practitioner and his/her corporation into a single enrollment; or, a sole proprietorship may have been enrolled as a corporation because the sole proprietorship was issued an Employer Identification Number (EIN) by the IRS.

These and similar situations may require physician/practitioners who are experiencing claims rejections to ensure their Medicare enrollment information, and that of their corporations (if they are incorporated), is correct. This may require the completion of the appropriate CMS-855 Medicare Provider Enrollment Application.

### ***Physicians/Practitioners Who Are Incorporated.***

Corporations include professional corporations, most limited liability companies, professional associations, and partnerships. Generally, the corporations that physicians/practitioners form are referred to as groups or group practices. Corporations are not sole proprietorships. When you are billing Medicare through your corporation, both you and your corporation must enroll in Medicare.

If you are a physician/practitioner who has established a corporation, you must obtain an NPI for yourself and an NPI for your corporation. A corporation applies for an NPI as an Entity type 2 (Organization) and you apply for an NPI as an Entity

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type 1 (Individual). If you, or your corporation, is not enrolled in Medicare, and you use the NPI of the non-enrolled entity in combination with the PIN of the enrolled entity (or vice versa), you will encounter claims problems because the combination is incompatible and will not be found in the Medicare NPI crosswalk. If the corporation will be billing Medicare, it may use only its NPI (once it has one), only its PIN (once it has one), or its NPI/PIN in combination (once it has both) to identify itself as the Billing/Pay-to Provider. Your NPI (once you have one), your PIN (once you have one), or your NPI/PIN combination (once you have both) would be used to identify you – the physician/practitioner – as the Rendering Provider. Until the enrollment application of the non-enrolled entity can be processed, you may want to use only the PIN or only the NPI of the enrolled entity to avoid claims processing problems.

### ***Physicians/Practitioners Who Have Sole Proprietorships.***

A sole proprietorship is a business whereby all of the business's assets and liabilities are tied directly to the physician/practitioner's (the sole proprietor's) Social Security account. The sole proprietor and the sole proprietorship are considered a single legal entity: an individual. The sole proprietor's Social Security Number (SSN) serves as the Taxpayer Identification Number (TIN) of the sole proprietorship. Often, the Internal Revenue Service (IRS) issues an Employer Identification Number (EIN) to a sole proprietorship to protect the sole proprietor's SSN from being disclosed on W-2s and in transactions, such as claims sent to health plans. Therefore, at the option of the sole proprietor, the EIN (if issued) instead of the SSN could be used as the TIN in submitting a sole proprietorship's Medicare claims. The IRS links that EIN to the sole proprietor's SSN for tax reporting purposes. You/your sole proprietorship must be enrolled in Medicare

If you are a physician/practitioner who has a sole proprietorship, you must obtain an NPI for yourself as an Entity type 1 (Individual). There is no separate NPI for the sole proprietorship. When you/your sole proprietorship are billing Medicare, you may use only your NPI (once you have one), only your PIN (once you have one), or your NPI and PIN in combination (once you have both) to identify yourself as the Billing/Pay-to Provider and as the Rendering Provider.

### ***Physicians/Practitioners Who Have No Private Practice.***

You must be enrolled in Medicare in order for the services you render to Medicare beneficiaries to be reimbursed by the Medicare program. If you do not have a sole proprietorship and have not formed a corporation, you do not bill Medicare directly; instead, you reassign your benefits to another entity, usually a group or group practice, and the group or group practice bills Medicare for the services that you perform. That group or group practice must also be enrolled in Medicare, but you are not responsible for the enrollment of the group or group practice. The group or

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group practice would submit claims in which you would be identified as a Rendering Provider.

You must obtain an NPI for yourself as an Entity type 1 (Individual). The group would be responsible for ensuring that you are appropriately identified in the group's claims; that is, the group would ensure that your NPI (once you have one) is used with the compatible PIN (your PIN, once you have one) if using the NPI/PIN combination; or, the group may use only your NPI (once you have one) or only your PIN (once you have one) to identify you as the Rendering Provider. The group must have its own NPI and would use only the NPI (the group's NPI, once it has one), only the PIN (the group's PIN, once it has one), or the NPI (the group's NPI, once it has one) with the compatible PIN (the group's PIN, once it has one) in combination to identify itself as the Billing Pay-to Provider.

### ***New Product to Assist Physicians/Practitioners in Understanding Medicare Enrollment***

All physician/practitioners, including sole proprietors and incorporated physician/practitioners, applying for enrollment in Medicare must have the appropriate NPI(s) and must report those NPIs on the CMS-855 Medicare Provider Enrollment Application. Physician/practitioners must also report the NPI(s) of the corporations, sole proprietorships, groups, or group practices to which they will be reassigning their benefits. Further information on enrollment scenarios is now available at

<http://www.cms.hhs.gov/Medicareprovidersupenroll/Downloads/EnrollmentNPI.pdf> on the CMS website. General Medicare enrollment information can be found at <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS website.

### ***If Your Claims Are Rejected***

- Check Medicare Reject Report messages.
- If you use billing companies, clearinghouses, and administrative staff, check to find out if they have been contacted by Medicare carriers or A/B MACs concerning problems in matching NPI/PIN combinations to the Medicare NPI crosswalk.
- Check your information (and that of your corporation, if you formed one) in the NPPES to ensure that the NPI(s) were properly obtained. For example, if you are have a sole proprietorship, you should have an individual PIN and you should have obtained an NPI as an Individual (Entity type 1), not as an Organization (Entity type 2).
- Ensure that the NPPES data (for you and your corporation, if you formed one) are correct, and that the NPPES record(s) contains the Medicare legacy identifier(s) *that was assigned to the provider (physician/practitioner or the corporation) to whom the NPPES record belongs*. For example, a

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physician/practitioner applying for an NPI would list his/her Medicare PIN in the "Other Provider Identifiers" section of the NPI application, but would not list the PIN of the group in which he/she is a member. Medicare uses this information in building the Medicare NPI crosswalk and incorrect reporting will flow into the NPI crosswalk and cause problems down the road. To view or edit your NPPES record, go to <https://nppes.cms.hhs.gov> on the CMS website. For assistance, call the NPI Enumerator at 1-800-465-3203.

- If the NPI(s) was properly obtained and the NPPES information is correct and you continue to get informational NPI edits: Ensure that your (and your corporation's, if you formed one) Medicare enrollment information is up to date. If the carrier or A/B MAC asks that you or your corporation re-enroll or update the enrollment information, ensure that a *complete* application is submitted (CMS-855I and, if appropriate, CMS-855R). When completing the CMS-855I or CMS-855R, list your NPI and the NPI of the corporation (group practice) to which benefits will be reassigned (if applicable) in the appropriate places on the CMS-855I and, if the CMS-855R is necessary, on the CMS-855R. Be sure to also list the NPI and the PIN of the corporation (group practice) in the appropriate places on the CMS-855I and, if the CMS-855R is necessary, on the CMS-855R (if PINs have been assigned). The Medicare document referenced earlier will assist you in doing this. Also, make sure that the Medicare enrollment record reflects the correct Taxpayer Identification Number (TIN) for use by Medicare in reporting your income to the IRS on the 1099 form. For example, if you are an incorporated physician/practitioner, your Medicare payments need to be associated with your corporation's TIN and not your SSN. If the enrollment record does not reflect this, a CMS-855I must be completed in order to update it.

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**MEDICARE**  
**PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT**

**Name(s) and Address of Participant\***

**Physician or Supplier  
Identification Code(s)\***

Name

Address

City

State

Zip Code

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 January 1st, 2008.

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

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

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

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

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

\_\_\_\_\_  
Date

(including area code)  
Office phone number

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

Received by  
(name of carrier)

Effective date

Initials of carrier official

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington D.C. 20503.







































































































