Program Memorandum Carriers

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

Transmittal B-01-65 **Date: OCTOBER 26, 2001**

CHANGE REQUEST 1900

SUBJECT: Calendar Year (CY) 2002 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

The annual participation enrollment program for calendar year 2002 will commence on November 26, 2001, and will run through January 7, 2002.

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

- A Participation Announcement;
- A Blank Participation Agreement; and
- A Year 2002 Fact Sheet.

The information contained in the 2002 Fact Sheet is to be treated as confidential. The Fact Sheet is subject to change during the regulation clearance process and must not be released prior to the publication of the Final Rule implementing the Fee Schedule for Physician Services for CY 2002. We will notify the regional offices if any information in the Fact Sheet changes during the clearance process.

Reproduce these attachments for your participation enrollment/fee disclosure packages. (See Medicare Carriers Manual (MCM) §17001.1 for fee disclosure guidelines.) For CY 2002 disclosure reports, display fee data as follows:

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

For CY 2002 disclosure reports, also provide the anesthesia conversion factors.

Mail participation enrollment/fee disclosure packages via first class or equivalent delivery service, and schedule the release of this material so that providers receive it no later than November 26, 2001.

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

The Center for Beneficiary Choices, Demonstration and Data Analysis Group released the Medicare Physician Fee Schedule Database (MPFSDB) and the anesthesia conversion factors to carriers electronically on October 29, 2001.

The carriers have an option of receiving one of two files: (a) they can receive a file which contains data for the entire country (DSN = MU00.@BF12390.MPFS.CY02.C00000.V1017) or (b) they can receive a file which only contains data for their processing site. If a carrier chooses the first option, please remind staff that many carriers had difficulty previously receiving this file because of its size.

In addition, carriers can retrieve the file MU00.@BF12390.MPFS.CY02.ANES.V017 which contains the anesthesia conversion factors.

The processing site specific 2002 MPFSDB files, that were released on October 29, 2001, contained extraneous records at the end of the file.

To facilitate the share systems processing, corrected files have been created and are named:

MU00.@BF12390.MPFS.CY02.C00510.V1031	for 00510
MU00.@BF12390.MPFS.CY02.C00630.V1031	for 00630
MU00.@BF12390.MPFS.CY02.C00660.V1031	for 00660
MU00.@BF12390.MPFS.CY02.C00803.V1031	for 00803
MU00.@BF12390.MPFS.CY02.C00880.V1031	for 00880
MU00.@BF12390.MPFS.CY02.C00973.V1031	for 00973
MU00.@BF12390.MPFS.CY02.C14330.V1031	for 14330
MU00.@BF12390.MPFS.CY02.CARKBS.V1031	for 00520,00528
MU00.@BF12390.MPFS.CY02.CCIGNA.V1031	for 05130,05440,05535
MU00.@BF12390.MPFS.CY02.CEDS01.V1031	for 00801,00951,00952,00953, 16360,16510,31142,31143,31144,31145, 31146
MU00.@BF12390.MPFS.CY02.CEDS02.V1031	for 00820,00824,00825,00826, 00831,00832,00833,00834,00835,00836
MU00.@BF12390.MPFS.CY02.CGTE00.V1031	for 00511,00521,00522,00523, 00590,00751,00910
MU00.@BF12390.MPFS.CY02.CHPBSS.V1031	for 00512,00591,00870,00904,00954
MU00.@BF12390.MPFS.CY02.CKANBS.V1031	for 00650,00655,00740
MU00.@BF12390.MPFS.CY02.C00805.V1031	for 00805
MU00.@BF12390.MPFS.CY02.C00865.V1031	for 00865
MU00.@BF12390.MPFS.CY02.CTEXBS.V1031	for 00900,00901,00902,00903

These new files are available for immediate receipt.

Alternatively, the extraneous records could be bypassed; they are identifiable by the existence of spaces in the year field (first four positions) of the data record.

The national file MU00.@BF12390.MPFS.CY02.C00000.V1017 does not contain the extraneous records.

The MPFSDB will contain the CY 2002 fee schedule amounts for procedure codes with status indicators of A, T, D, H, and R if Relative Value Units (RVUs) have been established by CMS. Carriers are also to include drug allowances (status code E) for disclosure purposes.

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

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

Include language in a bulletin that provides an explanation of the facility-based fee concept (e.g., facility-based fees are linked to their own separate RVUs independent of the non-facility RVUs).

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

Participation Agreements Received Prior to January 1, 2002

Physicians and practitioners who submit their participation enrollment or withdrawal forms prior to January 1, 2002, should submit claims for 2002 dates of service in accordance with the decision made. For 2002 enrollment and withdrawal forms received prior to January 1, 2002, update your participation files in conjunction with the installation of 2002 fees.

Participation Agreements Received After December 31, 2001, But Before January 7, 2002

Although the participation enrollment period will run through January 7, 2002, the participation agreement is effective January 1, 2002. Physicians and practitioners who submit their 2002 participation election or withdrawal forms after December 31, 2001, must begin to bill in accordance with their decision once it is submitted to you. Enrollments and withdrawals for 2002 that are received after December 31, 2001, and before January 7, 2002, should be recorded within your system as soon as possible to ensure accurate processing of claims for 2002 services. Until such time as a timely filed 2002 participation election or withdrawal is received, use the provider's 2001 participation status for processing 2002 claims.

Claims for dates of service on or after January 1, 2002, that are processed prior to your receipt of a participation election or withdrawal for 2002 should not be routinely reopened/reprocessed. However, if a physician requests to reopen previously processed claims for dates of service on or after January 1, 2002, due to the impact of the extended enrollment period, make accommodations for reopening such claims. Moreover, as of, January 7, 2002, the participation status will be irrevocable for calendar year 2002 services.

Revised Due Dates for Loading Medicare Participating Physician/Supplier Directories and for Reporting Participation Data to CMS

The date for loading the 2002 Medicare Participating Physician/Supplier Directories and for reporting Participation Data to CMS is February 25, 2002.

Furnishing Participation Physician/Supplier Information

Do not print hardcopy participation directories (i.e., MEDPARDs) for CY 2002 without regional office prior authorization and advance approved funding for this purpose. Supplemental budget requests (SBRs) for CY 2002 MEDPARD directories will not be approved. Load MEDPARD-equivalent information on your Internet Website (if you have one). Notify providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. Also, inform hospitals and other organizations (e.g., Social Security offices, area Administration on Aging Offices, and other beneficiary advocacy organizations) how to access MEDPARD information on your Website.

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

Online Participating Physician Directory

As part of the ongoing effort to provide Medicare beneficiaries with information to help them make health care choices, CMS has a participating physician directory at www.medicare.gov, CMS's beneficiary Website. The directory can be accessed from the home page under the section titled *Participating Physician Directory.* The directory contains names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment on claims for all services.

The information in the database comes from the Unique Physician Identification Number (UPIN) Registry which was provided by you. Please be aware that we have instructed physicians to contact you directly if their information appearing on the Website is incorrect, has changed, or does not appear. The directory is updated monthly. Corrections or changes to the information will be reflected on the Website, the month after you submit an update to the UPIN registry.

Key Implementation Dates

- MPFSDB released to carriers - October 29, 2001
- Delivery of participation material begins (for receipt no later than November 26, 2001) - November 19, 2001
- Participation enrollment period begins - November 26, 2001
- Participation enrollment period ends - January 7, 2002

The effective date for this PM is October 29, 2001.

The implementation date for this PM is November 26, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after November 26, 2002.

Contractors should direct questions to the appropriate regional office. Regional office staff can direct their questions on carrier operations to Susan Myers on (410) 786-6987 or Melvia Page on (410) 786-4727 and payment policy to Joan Mitchell on (410) 786-4508.

Attachments

Announcement
About Medicare Participation for Calendar Year 2002

All physicians, practitioners and suppliers must make their calendar year (CY) 2002 Medicare participation decision by January 7, 2002.

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2002.

WHY PARTICIPATE?

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

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

The number of physicians, practitioners and suppliers who choose to participate in Medicare continues to grow. During CY 2001, 88.7 percent of all physicians, practitioners and suppliers are billing under signed Medicare participation agreements - this was a 0.4 percent increase over the number of CY 2000 participants.

WHAT TO DO

If you choose to be a participant in CY 2002:

- 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 2002:

- 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, 2002. This written notice must be postmarked prior to January 7, 2002.

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 2002.

We hope you will decide to be a Medicare participant in CY 2002.

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

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant* **Physician or Supplier Identification Code(s)***

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

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

2. Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective January 1, 2002.

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

Office phone number
(including area code)

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

FORM CMS-460

Received by
(name of carrier)

Effective date

Initials of carrier official

2002 FACT SHEET

FOR PHYSICIANS AND OTHER PROVIDERS: KEY NEWS FROM MEDICARE FOR 2002

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

1. Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration)

On July 1, 2001, the Health Care Financing Administration (HCFA) became the Centers for Medicare & Medicaid Services (CMS). The Secretary of Health and Human Services Tommy G. Thompson announced this change to reflect that "we are making quality service the number one priority of the agency." He emphasized that it is more than a new name - it is an increased emphasis on responsiveness to beneficiaries, physicians, and providers, and to quality improvement.

2. Physician Edition of "Medicare and You"

The Physician Edition of Medicare & You 2002 is being mailed to participating physicians in early November. This edition includes the national edition of the beneficiary handbook, as well as nine additional pages of information specifically of interest to the physician community. If you have not received your copy, call 1-800-MEDICARE (1-800-633-4227) to request a copy.

3. Relevant Patient Brochures That May Be Of Interest To Physicians

A number of beneficiary publications may be of interest to physicians in light of frequently asked coverage-related questions. They include the following: Medicare and Your Mental Health Benefits (Publication #10184), Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam and Clinical Breast Exam (Publication #02248), and Choosing Long-term Care: A Guide for People with Medicare (Publication #02223 – will be available in late Fall). A complete list of Medicare publications for beneficiaries is available at ***www.medicare.gov***. In addition to English, many publications are available in Spanish, Braille, audiocassette, and large print. A number of publications are also available in Chinese. To order copies for your office, fax your request to (410) 786-1905, and include the name of a contact person, phone number, and mailing address. (No P.O. Boxes, please).

4. Development of Web-based Medicare/Medicaid Program Manual

In an effort to improve customer service and establish greater efficiency in program operations and administration, CMS is restructuring its Medicare and Medicaid program manuals. Specifically, we are consolidating, updating, and streamlining our various program manuals into a single electronic, Web-based manual. Unlike the current paper manuals, the new Internet-only manual will be organized by functional areas. In addition, Web-based tools and techniques will allow us to be more responsive to user's needs by providing a single place to locate all program instructions, a more timely updating of instructions, and a faster method for finding information in the manual.

We will release Part 1, Medicare General Information, Eligibility, and Entitlement, on CMS's Website in November. The corresponding sections in the existing manuals will be retired as we release each part. The Internet address for the new Web-based Medicare/Medicaid Program Manual is http://www.hcfa.gov/pubforms/progman.htm. The address will soon be http://www.cms.hhs.gov/manuals.htm.

5. Development of a Physician Focused Website on MedLearn

CMS is in the process of developing a dynamic Website designed specifically for those physicians and their staff who serve Medicare beneficiaries. This site will be organized according to the health care delivery process and will include information such as provider enrollment, coverage, coding, and billing. It will also provide links to regulatory and policy sources.

6. Plan Now: Expect Flu Vaccine Supply Delays

The Centers for Disease Control and Prevention report that there will be a delay in the availability of some portion of influenza vaccine for the 2001-02 season. Although full quantities should be available by December, much of the vaccine will be distributed later in the season than usual. Therefore, providers are encouraged to continue vaccination efforts for all groups into December and later as long as the vaccine is available. Production of vaccine will continue through December, so providers who administer all of their supply early in the season and still have unvaccinated high-risk patients should plan to order and administer additional vaccine in December.

7. Advance Beneficiary Notices (ABNs) in Emergency Situations

An ABN should not be introduced in an emergency situation until the patient has been stabilized. For information on how to properly use an ABN without violating the Emergency Medical Treatment and Labor Act (EMTALA), please see our answers to your questions at: ***http://www.hcfa.gov/medlearn/refabn.htm***. Additional information here answers your questions on the use of ABNs for laboratory services, and your patients' questions on ABNs.

8. Revised Provider Enrollment Applications

Effective November 1, 2001, the 1/98 Form HCFA-855 will be replaced by Form CMS-855. Form HCFA-855C (Change of Information Request) will become obsolete. All change requests postmarked after December 31, 2001, must be submitted on the revised version of Form CMS-855 with a signed and dated certification statement.

9. Status of Evaluation and Management Documentation Guidelines (DGs)

Physicians have raised significant concerns about the physician documentation guidelines that Medicare uses for evaluation and management services. CMS is re-assessing our needs in an effort to respond to these concerns. We acknowledge that a physician's primary role is to provide clinical care. We are looking at ways to reduce the paperwork burden on physicians. Physicians billing codes should be sufficient to explain what was done without the additional documentation. We will work closely with the American Medical Association to encourage CPT code clarification and the reduction of the paperwork burden on physicians. Meanwhile, we will continue to use the 1995 and 1997 DGs for medical review of evaluation and management services.

New Benefits Under the Medicare, Medicaid, State Child Health Insurance Program Benefits Improvement and Protection Act (BIPA) of 2000 that Are Included in the Physician Fee Schedule

10. Screening for Glaucoma: Conditions for and Limitations on Coverage

Effective January 1, 2002, Medicare covers annual glaucoma screening exams for individuals with diabetes, a family history of glaucoma, or others determined to be at "high risk" for glaucoma. Under the new law, these screening services must be furnished by or under the direct supervision of an optometrist or ophthalmologist who is authorized under State law to furnish these services.

11. Colorectal Cancer Screening Tests: Coverage Expanded to Individuals not at High Risk

Beginning July 1, 2001, Medicare covers screening colonoscopies once every 10 years for individuals not at high risk for colorectal cancer. In the case of an individual who is not at high risk for colorectal cancer, but who had a screening flexible sigmoidoscopy paid for by Medicare within the last 4 years, the new law provides that payment may be made for a screening colonoscopy only after at least 47 months have passed following the month in which the last flexible sigmoidoscopy was performed.

12. Medical Nutrition Therapy Services

Beginning January 1, 2002, Medicare covers Medical Nutrition Therapy (MNT) services furnished by a registered dietitian or nutrition professional to beneficiaries with diabetes or renal disease. This new benefit will allow registered dietitians and nutrition professionals to receive direct Medicare payment for the first time.

13. Telehealth Services

Effective October 1, 2001, Medicare Part B coverage was expanded to include office or other outpatient visits, professional consultation, individual psychotherapy, and pharmacologic management via telehealth in rural Health Professional Shortage Areas and non-Metropolitan Statistical Area Counties. Those entities that are participating in Federal telemedicine demonstration projects that were approved by, or received funding from CMS as of December 31, 2000, are exempt from the geographic limitations on telehealth coverage. Under this new provision, the distant site practitioners will receive the full fee schedule amount for the telehealth service, and the originating site will receive a $20 facility fee. Payment will not be conditioned on the presence of a telepresenter.

Other Physician Fee Schedule Information

Revisions to the 2002 Medicare Physician Fee Schedule affect the amount you will receive when providing services to a Medicare beneficiary. Below is a summary of the major changes effective January 1, 2002, as well as other useful information. Full physician fee schedule information is attached.

14. Increases in Payment for Screening Mammography

Prior to January 1, 2002, screening mammography services were paid under a statutorily prescribed payment rate. Effective January 1, 2002, these services will be paid under the physician fee schedule. These are also new codes and payment amounts for mammography services using new technology, including computer-assisted devices.

15. Coverage for Biennial Screening Pap Smear and Pelvic Exams

Medicare covers biennial screening pap smears and pelvic exams, effective July 1, 2001. (Coverage previously was for once every 3 years.)

16. Five-Year Review of Work Relative Values

As required by law, we have completed a review of work relative values, and as part of this process, we received recommendations from the American Medical Association Specialty Society Relative Value Update Committee (RUC). We accepted the RUC recommendations for 92 percent of over 800 codes reviewed. Physician services that were affected by this process primarily involve services performed by specialties such as ophthalmology, urology, thoracic surgery, and vascular surgery.

17. The 4-Year Phase-in for the Resource-Based Practice Expense Payments Becomes Fully Effective in 2002.

The Medicare law requires a resource-based system for determining practice expense Relative Value Units (RVUs) for each physician service. The law requires the new payment system to be phased in over 4 years, effective for services furnished in 1999, with resource based practice expense RVUs being fully effective for 2002.

18. Services and Supplies Incident to a Physician's Professional Services

We allow auxiliary personnel to provide services incident to the services of physicians or practitioners who supervise them regardless of the employment relationship of the physicians or practitioners to the entity that employed the auxiliary personnel.

19. Correction to the 2001 Fact Sheet

The 2001 Fact Sheet you received last year contained information about Care Plan Oversight. The title of the subject was **Care Plan Oversight in Skilled Nursing Facilities and Hospices**. This was incorrect. The title should have been **Care Plan Oversight in Home Health Facilities and Hospices. Care plan oversight payments are not payable in a skilled nursing facility.**