



Medicare Basics Segment 2

Welcome to Medicare Basics, a program designed as a general overview of the Medicare program.

Segment 2: Becoming a Medicare Provider/ Supplier

Medicare Part B allows physician to enroll in the Medicare program. The Medicare Program defines physicians to include the following:

- Doctors of medicine and doctors of osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry or surgical chiropody or
- Doctors of optometry
- Chiropractors

In addition, the Medicare physician must be legally authorized to practice by a State in which he or she performs this function.

Interns and residents include physicians who:

- Participate in approved Graduate Medical Education (GME) programs; or
- Are not in approved GME programs, but are authorized to practice only in a hospital setting.

Also included in this definition are interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by Fiscal Intermediaries or A/B Medicare Administrative Contractors (MACs).

A teaching physician is a physician (other than an intern or resident) who involves residents in the care of his or her patients. Generally, the teaching physician must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service in order for it to be payable under the Medicare Physician Fee Schedule (MPFS).

Medicare defines a practitioner as any of the following to the extent that an individual is legally authorized to practice by the State and otherwise meets Medicare requirements:

- Physician's assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse midwife
- Clinical psychologist
- Clinical social worker or
- Registered dietician or nutrition professional

To obtain reimbursement from Medicare, providers and suppliers must first enroll in the program by completing the appropriate Form CMS-855, the Provider/Supplier Enrollment Application.



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The following forms are often required in addition to the CMS-855 form:

- Form CMS-588, the Medicare authorization agreement for electronic funds transfers;
- Form CMS-460, the agreement to become a Part B participating provider or supplier;
- Electronic Interchange Agreement;
- State medical license;
- Occupational or business license;
- Certificate of Use;
- NPI Notification.

You can find the Centers for Medicare & Medicaid Services (CMS) enrollment and agreement forms on www.cms.hhs.gov, the CMS Website. After all forms have been completed and signed, the packet is then mailed to the appropriate Medicare Contractor for processing. For most applicants, the enrollment process takes 60 days.

The National Provider Identifier (NPI) is a standard unique identifier that will replace health care provider identifiers that are now being used in standard transactions. It will eliminate the need to use different identification numbers when conducting Health Insurance Portability and Accountability Act (HIPAA) standard transactions such as eligibility and claim status inquiries with multiple plans.

Providers and suppliers must obtain a NPI before enrolling in Medicare, and those who enrolled prior to the NPI requirement must obtain a NPI in order to update their enrollment information.

NPI is required on all Medicare Claims for Part B March 1, 2008, and is the only number allowed to be on claims May 23, 2008, and later.

Upon acceptance into the Medicare Program, providers and suppliers are assigned certain identification numbers:

- The Provider Transaction Access Number (PTAN) (formerly the Provider Identification Number (PIN)) is an individual number assigned for accessing different systems:
 - Is assigned to the Medicare Part B physician/certain other practitioner/other supplier by Part B Carriers ,and
 - Is used in claims processing to identify who furnished the service to the beneficiary, is submitting the claim, and is to be reimbursed by Medicare.
 - PTANs are currently not required if the NPI is submitted on Part B claims.

Note: that PTANs are being replaced by NPIs in claims processing and other HIPAA standard transactions on May 23, 2008.

- The Unique Physician Identification Number (UPIN):
 - Was assigned to the physician/certain other practitioner – CMS stopped assigning UPINs on **June 28, 2007**;
 - Can be used in claims processing to identify the physician/certain other practitioner who orders services or refers patients to other providers;
 - May be used in any State where the physician/certain other practitioner orders or refers; and



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- Is required for consultations, routine foot care, durable medical equipment, orthotic/prosthetic devices, most diagnostic services, services by independently-practicing physical therapists and occupational therapists, and any other service that is ordered or referred.

Note: Submitters may continue to use UPINs as a secondary provider identifier until May 23, 2008 and UPINs are being replaced by NPIs in claims processing and other HIPAA standard transactions.

- The CMS Certification Number (CCN), formerly the Online Survey Certification and Reporting Number, identifies institutional providers and certain certified suppliers who meet Conditions of Participation or Coverage in the Medicare Program.

- This number is assigned by CMS Regional Offices.

Note: that CCNs are being replaced by NPIs in claims processing and other HIPAA standard transactions.

There are two types of providers and suppliers in Part B of the Medicare Program: participating and nonparticipating.

First we will discuss participating providers and suppliers. When you complete and sign Form CMS-460, you have formally notified CMS that you wish to participate in the Medicare Program and will accept assignment of benefits for all covered services for all Medicare patients. Assignment means that you will be paid the Medicare allowed amount as payment in full for your services.

Participation is for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Contractor Open Enrollment Period, which is usually in November. During this period, you can change your participation status for the following year. If you wish to continue participating, you do not need to sign an agreement each year.

As a participating provider or supplier, you will receive the following benefits:

- Five percent higher MPFS allowances;
- Limiting charge provisions are not applicable; and
- Included in the Medicare Participating Physician and Supplier Directory.

The nonparticipating provider or supplier may choose to accept assignment of Medicare claims on a claim-by-claim basis and may charge the beneficiary up to limiting charge, which is the maximum amount that can be charged for the services furnished (unless prohibited by State law).

The limiting charge is 115 percent of the MPFS amount and applies to the following regardless of who furnishes them or bills for them:

- Physicians' services;
- Services and supplies commonly furnished in physicians' offices that are incident to physicians' services;
- Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and



- Radiation therapy services.

This chart depicts the payment amounts that participating and nonparticipating providers and suppliers receive.

Note that the coinsurance amount due to the provider or supplier is paid after the deductible has been met. And payment for nonassigned claims goes to the beneficiary, who is responsible for paying the provider or supplier.

	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	\$125.00	\$125.00	\$109.25
MPFS Allowed Amount	\$100.00	\$ 95.00	\$ 95.00
80 Percent of MPFS Allowed Amount	\$ 80.00	\$ 76.00	\$ 76.00
Beneficiary Coinsurance Due to Provider/Supplier	\$ 20.00	\$ 19.00	\$ 33.25
Total Payment to Provider/Supplier	\$100.00	\$ 95.00	\$109.25 (\$95.00 x 1.15, limiting charge)

Submit new applications and changes of information to the appropriate provider enrollment address listed below.

WPS Medicare Part B
Provider Enrollment
P.O. Box 8248
Madison, WI 53708

The Clinical Laboratory Improvement Amendments (CLIA) of 1988 require all laboratory testing sites to have one of the listed certificates to legally perform clinical laboratory testing.

Certain CLIA Certificates that have been issued may limit the holder to perform only certain tests. Those procedures billed should accurately reflect those services authorized by the CLIA program and no other procedures. There are only two types of CLIA certificates that limit holders to certain test procedures: Certificate of Waiver or Certificate of Physician Performed Microscopy Procedures (PPMP). Performing tests without CLIA approval is a violation of the Clinical Laboratory Improvement Amendments of 1988 and may be punishable by fines and imprisonment.

NOTE: a CLIA Waived Test still requires the provider to include their CLIA number in Item 23 of the CMS-1500 Claim Form/Loop 2300 of the ANSI 837 4010A1.



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The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed at this link http://www.wpsmedicare.com/mac/education/b_type_lab_cliaupdate.pdf are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (i.e., CPT codes: 81002, 81025, 82270, 82272, G0394, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.