This section of the guide introduces billers to the general rules for becoming a Medicare Part B provider as either a physician or supplier. Although the clinical decisions of what services a beneficiary may need or receive is the responsibility of the treating physicians and other non-physician health care providers, billing personnel of any provider’s office are the principal point of contact between the beneficiary, the treating clinician, and the Medicare Contractor. In this capacity, the provider’s billing personnel must be aware of the many rules and regulations that apply to the setting for which they are submitting claims, as well as the limiting charge placed on services billed on a non-assigned claim. This section of the guide discusses the various types of Part B providers under Medicare, the general rules and processes with which individuals and groups/clinics must comply to enroll as a Medicare Part B provider, and the various Medicare reimbursement systems that affect physicians and suppliers.

Before a physician or supplier may submit claims to Medicare, the physician or supplier must first be enrolled as a Medicare provider. If the physician or supplier does not enroll they cannot receive payments for Medicare covered services. The process of enrollment, or of updating enrollment status, begins with the completion of an enrollment application. The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare Program and to ensure that CMS is in compliance with all regulatory requirements. The information collected from the enrollment application is used to ensure that payments made from the Medicare Trust Fund are only paid to qualified health care providers, and that the payment amounts are correct. This information also identifies that a provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking privileges to submit claims within the Medicare Program.

**WHAT ARE THE TYPES OF MEDICARE PROVIDERS?**

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

- Physicians
- Nurse practitioners
- Clinical psychologists
- Clinical Social Workers
- Physical therapists in private practice
- Occupational therapists in private practice
- Ambulance service suppliers
WHAT INFORMATION IS NEEDED TO ENROLL AS A MEDICARE PROVIDER?

Medicare requires the following information to enroll a provider:

- The type of health care provider
- What qualifies this provider as a health care-related provider of services and/or supplies
- Where this provider intends to render these services and/or furnish supplies
- Those persons or entities with an ownership interest or managerial control over the provider

THE ROLE OF MEDICARE CONTRACTORS IN PROVIDER ENROLLMENT

Medicare Contractors include Fiscal Intermediaries (FIs) and Carriers. Carriers are private insurance companies with which the Centers for Medicare and Medicaid Services (CMS) contracts to perform provider enrollment, claims processing, and adjudication functions, as well as make payments to physicians/practitioners and other health care suppliers on behalf of Medicare. Carriers make all final enrollment decisions. Durable Medical Equipment Regional Carriers (DMERCs) and Durable Medical Equipment Administrative Contractors (DME MACs) are Carriers that contract with Medicare to pay bills for medical equipment and supplies. The type of Carrier that processes Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims is the National Supplier Clearinghouse (NSC).

FIs are private insurance companies with which CMS contracts to perform provider enrollment and claims processing on behalf of Medicare. Home health and hospice claims are handled by special FIs called Regional Home Health Intermediaries (RHHIs). Other, less common or rural facility types [e.g., Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)] may have a single national FI or a specialized regional FI.

As discussed in Section 1, Who Processes Medicare Claims?, of this guide, all Medicare Contractors are in the process of being transitioned over as Medicare Administrative Contractors (MACs) per the Medicare Contracting Reform (MCR) update.

THE ROLE OF STATE AGENCIES IN PROVIDER ENROLLMENT

The state agency is a government agency within a provider’s state government system that is responsible for certifying the provider type(s) for which a facility is qualified to submit Medicare claims. State agencies conduct onsite inspections and other quality of care functions for the Medicare and Medicaid Programs and coordinate efforts with FIs in the institutional provider enrollment process.

Locating State Agencies

A list of state agencies may be found at: www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp on the CMS website.

Detailed information about state operations can be found in the Medicare State Operations Manual at www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. Search for publication #100-07.
Physicians or suppliers must enroll in the Medicare Program to receive payment for covered services. This involves completion of the appropriate Form CMS-855 provider/supplier enrollment application that collects payment and other general information about the provider and secures documentation to ensure a provider is qualified and eligible to enroll in the Medicare Program as a Medicare Part B Provider. The Carrier assists providers in determining the appropriate form to use and form sections to complete. After the completed form is submitted, the Carrier will verify all submitted information. It is important that the providers respond to the Carrier as soon as possible if asked for more information during the enrollment process. Failure to do so may delay enrollment into the Medicare Program.

Providers must simultaneously contact their state agency that handles site surveys to determine if one is required for their provider type(s). Although the Centers for Medicare & Medicaid Services (CMS) Regional Office is ultimately responsible for deciding whether a provider may participate in the Medicare Program, the state agency submits evidence and recommendations for Regional Office determination. Failure to contact the state agency may delay enrollment into the Medicare Program.

Physicians and suppliers are required to submit the appropriate Form CMS-855 when the provider has a change of information within 90 days of the effective date of the change. When the provider is providing notification of a change of ownership (referred to as a CHOW) or a change in control, notification of the change must be submitted within 30 days of the effective date of the change. If a physician or supplier is enrolled as a Medicare provider but never completed the appropriate Form CMS-855 as a Medicare provider, the provider must notify the appropriate Carrier when any changes occur.

Per the Medicare Program Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment Final Rule, effective June 20, 2006, all providers must complete the reenrollment process a minimum of once every 5 years to verify accuracy of enrollment information. Additional information within the Final Rule is available at www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms6002f.pdf on the CMS website.

If the state agency approves the application, the enrollment department will notify the applicant. Notification includes the provider’s unique Medicare billing number that is used in all communication with the payment contractor. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier. All HIPAA covered healthcare providers, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider’s NPI will not change. The NPI remains with the provider regardless of job or location changes.
Starting May 23, 2007, the NPI will replace all of the existing provider numbers that are used to bill Medicare, Medicaid, and other health care payers. Small health plans must use only the NPI by May 23, 2008.

CMS has revised the Form CMS-855 series of Medicare provider enrollment applications to include the NPI. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their NPI number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

NPI Additional Information

For additional information about the NPI, please go to www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

State Requirements for Provider Type Certification

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

WHAT MEDICARE PROVIDER ENROLLMENT FORMS SHOULD BE SUBMITTED?

Medicare requires physicians and suppliers to submit specific forms to enroll or update enrollment status.

Enrolling or Updating Enrollment Status

Each provider/supplier setting has very specific instructions for enrollment and for changing enrollment status. Detailed information can be accessed at www.cms.hhs.gov/MedicareProviderSupEnroll/ on the CMS website.

Since the type of information required for enrollment/updates varies by the type of provider, CMS created the following five different versions of Form CMS-855 for enrollment that are easier for providers to complete:

- Form CMS-855A - Medicare Enrollment Application - Institutional Providers
- Form CMS-855B - Medicare Enrollment Application - Clinics/Group Practices and Certain Other Suppliers
- Form CMS-855I - Medicare Enrollment Application - Physicians and Non-Physician Practitioners
- Form CMS-855R - Medicare Enrollment Application - Reassignment of Medicare Benefits
- Form CMS-855S - Medicare Enrollment Application - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

The five forms listed above are available for download in Portable Document Format (PDF) at www.cms.hhs.gov/CMSForms/CMSForms/ list.asp on the CMS website. These versions of these forms can be opened using Adobe Reader, a program available for download at no charge at www.adobe.com on the Web. PDF files cannot be used to enter information electronically; to use these forms, print a paper copy and either write or type the required information.

User guides and other software support are also available for the electronic forms. The electronic format will allow providers and suppliers to complete the forms and save information for
future use (e.g., if the provider or supplier must report changes). The electronic format will provide real-time edit checks and instructions for completing the form.

**Revised CMS-855 Enrollment Applications**

On May 1, 2006, CMS issued revised Form CMS-855 Medicare enrollment applications. Significant changes to the applications include the following:

- Requiring submission of the National Provider Identifier (NPI)
- Requiring that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (EFT) (Form CMS-855) when initially enrolling or, if they are currently not receiving payments via EFT, making a change to their enrollment information
- Removing Section 9 (Electronic Claims Submission Information), Section 10 (Staffing Companies), and Section 11 (Surety Bonds) from the application

These forms cannot be submitted electronically; rather the forms must be printed and submitted in hardcopy format. The form must be signed, dated, and mailed to the contractor for the provider’s locality.

**Determining Local Contractors**

An applicant can determine the current contractor for a particular locality at [www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage](http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage) on the CMS website.

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

- **Form CMS-588** - Authorization Agreement for Electronic Funds Transfer (EFT)
- **Form CMS-460** - Medicare Participating Physician or Supplier Agreement
- **Electronic Data Interchange (EDI) Agreement** - Medicare authorization for submitting electronic data

If a physician or supplier has any questions regarding the proper completion of any of these forms, he or she should contact the appropriate Medicare Contractor for assistance. Table 2-1 summarizes the key contacts and application forms that are required to enroll as a Medicare provider and indicates whether an on-site survey and certification is required for each type of Medicare provider.

**CMS Enrollment Forms and Instructions**

All of the CMS enrollment forms and user guidance for completing the forms are available at [www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp](http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp) on the CMS website.

**Additional Enrollment and Certification Information**

Additional enrollment or certification requirements may be necessary. More specific information can be accessed at [www.cms.hhs.gov/MedicareProviderSupEnroll/](http://www.cms.hhs.gov/MedicareProviderSupEnroll/) on the CMS website.
### Table 2-1. Provider Enrollment Contacts and Survey Requirements

<table>
<thead>
<tr>
<th>Enrollment Form Type</th>
<th>Provider/Supplier Type Affected</th>
<th>Who Should Complete This Form</th>
<th>Contacts</th>
</tr>
</thead>
</table>
| CMS-855A             | Community Mental Health Center (CMHC), Comprehensive Outpatient Rehabilitation Facility (CORF), End Stage Renal Disease (ESRD) Facility/Renal Dialysis Facility (RDF), Federally Qualified Health Center (FQHC), Histocompatibility Laboratory, Home Health Agency (HHA), Hospice, Hospitals (All), Indian Health Services (IHS) Facility, Organ Procurement Organization, Outpatient Physical Therapy, Occupational Therapy/Speech Language Pathology Services, Religious Non-medical Health Care Institution (RNHI)*, Rural Health Clinic (RHC), Skilled Nursing Facility (SNF) | If you are a health care organization and you:  
  - Plan to bill Medicare for Part A medical services provided to Medicare beneficiaries  
  - Are already enrolled in Medicare and need to make changes to your enrollment data. A change must be reported within 90 days of the change. | Fiscal Intermediary (FI)  
State Agency for Survey and Certification  
*For RNHIs only, the Boston Regional Office has primary responsibility for the survey and certification process. |
| CMS-855B             | Hospital Department(s), Multi-specialty Clinic, Physical/ Occupational Therapy Group in Private Practice, Public Health/Welfare Agency, Single Specialty Clinic, Ambulance Service Supplier, Ambulatory Surgical Center (ASC), Independent Clinical Laboratory, Independent Diagnostic Testing Facility (IDTF), Mammography Center, Mass Immunization Roster Biller Only | If you are a group/organization who plans to bill Medicare for Part B medical services provided to Medicare beneficiaries, and you are:  
  - A medical practice or clinic that will bill for Medicare Part B practitioner services provided by group practices, clinics, independent laboratories, portable X-ray suppliers, or physical therapists in private practice. | Carrier  
State Agency for Survey and Certification as applicable |
<table>
<thead>
<tr>
<th>Enrollment Form Type</th>
<th>Provider/Supplier Type Affected</th>
<th>Who Should Complete This Form</th>
<th>Contacts</th>
</tr>
</thead>
</table>
| CMS-855B (Con’t)     | Part B CAP Drug Vendor, Portable X-ray Supplier, Radiation Therapy Center, Slide Preparation Facility, Voluntary Health/Charitable Agency | - A hospital or other medical practice or clinic that may bill for Medicare Part A services but that will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other Medicare Part B billing entities.
- Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor’s jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- Currently enrolled in Medicare and need to make changes to your business (e.g., you have added or changed a practice location). Changes must be reported within 90 days of the effective date of change. | Carrier State Agency for Survey and Certification as applicable |
| CMS-855I             | Anesthesiology Assistant, Audiologist, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, Clinical Social Worker, Mass Immunization Roster Biller, Nurse Practitioner, Occupational Therapist in Private Practice | If you are an individual practitioner who plans to bill Medicare for Part B medical services provided to Medicare beneficiaries and you are:
- An individual practitioner who will provide services in a private setting.
- An individual practitioner who will provide services in a group setting. If you plan to render all of your services in a group setting, you will complete Sections 1-4 and skip to Sections 14-17. | Carrier State Agency for Survey and Certification as applicable |
<table>
<thead>
<tr>
<th>Enrollment Form Type</th>
<th>Provider/Supplier Type Affected</th>
<th>Who Should Complete This Form</th>
<th>Contacts</th>
</tr>
</thead>
</table>
| CMS-855I (Con’t)     | Physical Therapist in Private Practice, Physician Assistant, Psychologist, Clinical Psychologist Billing Independently, Registered Dietitian or Nutrition Professional, and all Physician Specialties. | ✗ Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor’s jurisdiction (e.g., you have opened a practice location in a geographic territory served by another Medicare fee-for-service contractor).  
✗ Currently enrolled in Medicare and need to make changes to your information (e.g., you have added or changed a practice location).  
✗ An individual who has formed a professional corporation, professional association or a limited liability company for which you are the sole owner. | Carrier  
State Agency for Survey and Certification as applicable |
| CMS-855S             | Medical Supply Company, Medical Supply Company with Registered Pharmacist, Medical Supply Company with Respiratory Therapist, Medical Supply Company with Orthotics Personnel, Medical Supply Company with Prosthetics Personnel, If you plan to bill Medicare for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries and you are:  
✗ Enrolling in Medicare for the first time as a DMEPOS supplier.  
✗ Currently enrolled in Medicare as a DMEPOS supplier and need to make changes to your business, other than enrolling a new business location (e.g., you are adding, deleting, or changing existing information under this Medicare Supplier Billing Number). Changes must be reported within 30 days of the effective date of change. | Durable Medical Equipment (DME)  
Medicare Administrative Contractor (MAC)  
National Supplier Clearinghouse (NSC)  
State Agency for Survey and Certification are not applicable |
<table>
<thead>
<tr>
<th>Enrollment Form Type</th>
<th>Provider/Supplier Type Affected</th>
<th>Who Should Complete This Form</th>
<th>Contacts</th>
</tr>
</thead>
</table>
| CMS-855S (Con’t)     | Medical Supply Company with Prosthetic/Orthotic Personnel, Medical Supply Company with Pedorthic Personnel, Orthotics Personnel, Pedorthic Personnel, Prosthetics Personnel, Prosthetic/Orthotic Personnel, Rehabilitation Agency, Optician, Optometrist Home Health Agency (HHA), Skilled Nursing Facility (SNF), Intermediate Care Nursing Facility, Nursing Facility (other), Pharmacy, Grocery Store, Department Store, Occupational Therapist, Physical Therapist, Physician, Hospital, Ambulatory Surgical Center (ASC), Rehabilitation Agency, Indian Health Service (IHS), Oxygen Supplier | ▶ Currently enrolled in Medicare as a DMEPOS supplier but need to enroll a new business location. This is to add a new location to an organization with a tax identification number already listed with the NSC. This differs from changing information on an already existing location.  
▶ Currently enrolled in Medicare as a DMEPOS supplier and have been asked to verify or update your information. This includes if you have been asked to attest that your organization is still eligible to receive Medicare payments.  
▶ Reactivating your Medicare DMEPOS Supplier Billing Number (e.g., your Medicare Supplier Billing Number was deactivated because of non-billing, and you wish to receive payment from Medicare for future claims).  
▶ Voluntarily terminating your Medicare DMEPOS Supplier Billing Number. | Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)  
National Supplier Clearinghouse (NSC)  
State Agency for Survey and Certification are not applicable |
Obtaining Help With Enrollment Issues

A provider can obtain assistance with enrollment issues or questions from the local contractor assigned to the geographic location in which the contractor is located. A complete list of contractors is available at www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage on the CMS website.

WHAT ARE THE STAGES OF THE ENROLLMENT PROCESS FOR PART B PROVIDERS?

Medicare has different enrollment processes depending upon the type of provider. When Medicare Part B providers enroll in the Medicare Program, the process generally proceeds as shown in Figure 2-1.

COMMON PROVIDER ENROLLMENT QUESTIONS

The following are common questions asked by physicians or suppliers when enrolling in the Medicare Program.

Who is the authorized representative?

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

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

What is the effective date of enrollment in Medicare?

This date varies by provider type. The enrollee should contact his or her local Carrier or the National Supplier Clearinghouse (NSC) for more information.

How long does the enrollment process typically take?

For most applicants, the application process will take 60 days. The Centers for Medicare & Medicaid Services (CMS) requires its contractors to process 80% of applications within 60 calendar days.

Figure 2-1. Medicare Enrollment Process
days of receipt or earlier, and process 99% of applications within 180 calendar days of receipt. If the applicant has not submitted all the necessary accompanying documentation, or the contractor has to request additional information, the contractor will contact the applicant initially by telephone to expedite the collection of any missing or additional information.

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

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

Using the appropriate Form CMS-855, a change of information should be submitted if you are changing, adding, or deleting information under your current tax identification number. Changes should be reported within 90 days of the change.

Per the Medicare Program Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment Final Rule, effective June 20, 2006, all providers must complete the re-enrollment process a minimum of once every 5 years to verify accuracy of enrollment information. Additional information within the Final Rule is available at [www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms6002f.pdf](http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms6002f.pdf) on the Centers for Medicare & Medicaid (CMS) website.

If you are already enrolled in Medicare and are not receiving Medicare payments via Electronic Funds Transfer (EFT), any change to your enrollment information will require you to submit a Form CMS-588 form. All future payments will then be received via EFT.

**Is a photocopy of Form CMS-855 acceptable?**

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

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

**Managing/Directing Employees**

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

**Owners**

Although the vast majority of non-profit organizations do not have owners, any individual who owns at least 5% of the non-profit organization must be reported in the Owner Information section of Form CMS-855.

If a non-profit organization has a unique organizational structure, the organization must contact their Carrier or NSC for more information.

**Who does Medicare recognize as a physician?**

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

The issuance by a state for a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards are used in determining whether a particular physician has legal authorization. If the state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.
Does Medicare recognize medical residents and interns for payment purposes?

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

Generally, the Fiscal Intermediary (FI) pays services provided by interns and residents as physician services when provided within the scope of his/her training program. Services furnished by interns and residents outside the scope of his or her training program, are reimbursable to the hospital under Part B, on a reasonable cost basis. These services include:

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

Intern and Resident Services Information

The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (previously titled Medicare Resident & New Physician Guide: Helping Health Care Professionals Navigate Medicare) provides additional details regarding intern and resident services furnished either under an approved training program, or outside an approved training program. The publication may be accessed and downloaded at www.cms.hhs.gov/MLNProducts/ on the CMS website.

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

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

- Advanced Registered Nurse Practitioners (ARNPs)
- Clinical Nurse Specialists (CNSs)
- Licensed Clinical Social Workers (LCSWs)
- Physician Assistants (PAs)

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

**Payment to Non-Physician Practitioners**

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

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

**What does “physician/supplier specialty” mean?**

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

**What is the difference between a PIN, UPIN, and NPI?**

Physicians receive and must use the following identifying numbers:

- **Provider Identification Number (PIN)** - used as a provider billing number to receive reimbursement
- **Unique Physician/Practitioner Identification Number (UPIN)** - used only when a service requires a referring or ordering physician; however, this number is never used as a provider billing number
- **National Provider Identifier (NPI) Number** - will be the single provider identifier, replacing the health care provider identifiers that are currently used in standard transactions

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

The 6-character alphanumeric UPIN is assigned by CMS and used to identify the Medicare provider. This number is assigned to physicians, non-physician practitioners, groups/clinics, and suppliers (excluding those billing to the Durable Medical Equipment Regional Carrier (DMERC)/Durable Medical Equipment Medicare Administrative Contractor (DME MAC) to identify the referring or ordering physician on a Medicare claim.

Each individual practitioner (physicians and non-physician practitioners only) receives one UPIN, regardless of the number of practice settings. The individual practitioner keeps the UPIN throughout his or her Medicare affiliation, regardless of the state in which he or she practices. CMS uses the UPIN to identify the ordering and referring physician, to aggregate payment and utilization information for individual practitioners, to ensure compliance with contractor recommendations for sanctions, and to validate duplicate services.
Medicare’s implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as described below:

- **Jan 3, 2006 - Oct 1, 2006:** Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI.

- **Oct 2, 2006 - May 22, 2007:** CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

- **May 23, 2007 - Forward:** CMS systems will only accept NPI numbers. Small health plans have an additional year in which to become NPI compliant.

### UPIN Requirements

A UPIN is required if the service is requested by:

- A referring physician who requests an item or service for a beneficiary, for which payment may be made under the Medicare Program; or

- An ordering physician who orders non-physician services for a beneficiary, such as diagnostic laboratory tests, clinical laboratory tests, or DME.

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

- Consultation services
- Routine foot care
- DME and other medical supplies
- Orthotics/prosthetic devices, including optical supplies

- Most diagnostic services, including laboratory and radiology services
- Services by independently-practicing physical or occupational therapists

### Surrogate UPINs

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

Ordering/referring physicians who may require a surrogate UPIN include:

- **RES000** - intern, resident, and fellow
- **VAD000** - active United States military physicians and those employed by the Department of Veterans Affairs (VA)
- **PHS000** - Public Health Service (PHS) physicians [including Indian Health Services (IHS)]
- **RET000** - retired physician (Note: Retired physicians must use their assigned UPIN)
- **OTH000** - when the ordering/referring physician has not received a UPIN and does not meet the criteria for one of the other surrogate UPINs; used until an individual UPIN is assigned.

When services requiring a UPIN are performed and no referring physician exists, the UPIN and name of the performing physician must be reported.
**What is an individual health care practitioner?**

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

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

**Can an individual health care practitioner have multiple Medicare numbers for different practice locations?**

The Medicare Contractor may issue more than one PIN depending upon the physician fee localities (geographic regions) in which a provider’s practices are located. The local Medicare Contractor will determine whether more than one billing number will be issued. Individuals furnishing services in multiple offices should contact their local Medicare Contractor to determine if more than one number will be issued.

**What is a physician-directed group/clinic practice?**

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

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

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

**How do individual health care practitioners join or leave a group?**

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

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

**What does “reassignment of benefit” mean?**

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

The term “participating provider” has different meanings for different provider types. For some physicians and suppliers that bill Part B Medicare Contractors, the physician or supplier may have flexibility regarding whether to accept Medicare payment as full payment for any or all of their patients. However, certified institutional providers that bill Part B Medicare Contractors are considered “participating” if the provider is enrolled in Medicare, and therefore must accept Medicare payment policies for all Medicare beneficiaries. By participating in the Medicare Program, the provider agrees to accept assignment for all covered services provided to Medicare patients. This means that they must accept Medicare payment as payment in full, except for any unmet deductible and coinsurance amount that is the patient’s responsibility.

Why would an enrollment application be denied or revoked?  

An enrollment application might be denied because the provider or supplier does not meet, or no longer meets, requirements listed in 42 CFR. Examples of such requirements include when the provider or supplier no longer meets an applicable federal or state requirement, or the provider or supplier no longer meets the requirements for a billing number.

What happens if my enrollment application is denied or revoked?  

If an enrollment application is denied or revoked, the provider or supplier should follow the appeal procedures listed within the denial/revocation letter sent to them by the Medicare Contractor who determined that the provider or supplier’s application for enrollment is denied or who revoked the provider or supplier’s enrollment privileges. Instructions for appeal are also explained within Chapter 10, Section 19, of the Medicare Program Integrity Manual available at www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. Search for publication #100-08.

HOW CAN A PART B PROVIDER SEEK MEDICARE REIMBURSEMENT?  

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

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

Deciding Whether to Participate

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

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

Changing Participation Status

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

Benefits of Participation

Benefits of becoming a participating provider include the following:

- **Eligibility Access:** A participating provider submitting Electronic Media Claims (EMCs) may access beneficiary eligibility files via vendor access (see Section 3 for more information).

- **Financial:** Medicare Fee Schedule allowances are about 5% higher for participating physicians. In addition, physicians who participate are not subject to limits on actual charges.

- **Medigap:** Claims with Medigap information will automatically cross over to the beneficiary’s supplemental insurer.

- **The Medicare Participating Physicians and Suppliers Directory (MEDPARD):** The MEDPARD contains a listing of all participating providers. Medicare Contractors maintain a toll-free telephone line that allows Medicare beneficiaries to request information about local participating providers. Some Medicare Contractors also maintain MEDPARD on their website. Beneficiaries may also access MEDPARD at www.medicare.gov on the Web where more detailed physician and supplier information is available, including maps and directions to participating providers.

**Note:** The directory located at www.medicare.gov on the Web provides an opportunity for physicians to submit updated information through an online feedback tool. The local Medicare Contractor can furnish information about the participation program.

The Non-Participating Provider:

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

**Note:** Pharmaceuticals, equipment, and supplies ARE NOT held to a limiting charge when submitting non-assigned claims.
Today, physicians and suppliers may be reimbursed through private contracts with Medicare managed care plans or through the Medicare fee-for-service plans. However, unlike in 1966, most Part B payment methodologies today are based upon federally-established predetermined payments per procedure or item, rather than on cost or charges. In addition, some supplies and services can no longer be billed to a Medicare Contractor if a beneficiary is concurrently receiving Part A services from a SNF or Home Health Agency (HHA).

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

**MEDICARE PART B REIMBURSEMENT**

Medicare Part B claim reimbursement is generally based on an established “fee-for-service” schedule for claims submitted by Part B physicians and suppliers. After deductibles, most Part B providers are reimbursed at 80% of the lower of either the established Fee Schedule, reasonable or customary (depending on the type of physician) charge, or their billed charge for the following services:

- Physicians’ services
- Ambulance transportation
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Diagnostic tests

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

- Clinical laboratory tests
- Influenza or pneumococcal pneumonia vaccinations
- Other exceptions, as defined by the Centers for Medicare & Medicaid Services (CMS)

**THE PART B MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)**

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

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

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

Physician Fee Schedules for all Medicare Part B providers are calculated using one national Conversion Factor (CF). Congress determines the CF each year, considering the projected inflation rate, projected versus actual claims volumes, Medicare enrollment changes, and other factors potentially impacting the Medicare Part B budget. Medicare Contractors and DMERCs may only establish local pricing for procedures that do not have an established national rate. The Fee Schedule is updated annually on January 1st. Part B providers are furnished their local Fee Schedule by their applicable Medicare Contractor or DMERC/DME MAC.
CMS Fee Schedule Lookup Resource

Billers who may be processing claims or claim denials can access the Medicare Physician Fee Schedule (MPFS) lookup resource at www.cms.hhs.gov/apps/pfslookup/step0.asp on the CMS website.

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

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

The site allows providers to:

- Search pricing amounts, various payment policy indicators, RVUs, and GPCCs by a single procedure code, a range, and a list of procedure codes for the previous 4 years.
- Search for the nation, a specific Carrier, or a specific Carrier locality. Each page has associated Help/Hint information available to complete the selections.

NON-FACILITY VERSUS FACILITY FEE SCHEDULE ADJUSTMENTS

Certain Part B services primarily performed in individual Part B provider’s office settings are subject to a payment limit if performed in one of the following:

- An inpatient or outpatient hospital setting
- A hospital emergency room
- A SNF
- A Comprehensive Outpatient Rehabilitation Facility (CORF)
- An Inpatient Rehabilitation Facility (IRF)
- An Inpatient Psychiatric Facility (IPF)
- An Ambulatory Surgery Center (ASC)

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

MEDICARE PART A REIMBURSEMENT

Although physicians and suppliers are not reimbursed by the Part A benefit, several Part A payment policies can influence payments to some physicians and suppliers. Today, most Part A providers such as hospitals, SNFs, and HHAs receive payments through a Prospective Payment System (PPS) designed to cover the costs of all items and services furnished to beneficiaries while they are under the care of that facility.
In other words, many items and services that previously were billable to Medicare Contractors are now covered under “Consolidated Billing” provisions of the Part A PPS system. This means that many Durable Medical Equipment (DME) items and services (e.g., physical therapy services) must be billed to the Fiscal Intermediary (FI) by the facility, even if they were furnished by a Part B provider under arrangement.

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

**MEDICARE MANAGED CARE REIMBURSEMENT**

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

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