Medicare Part B - Current Updates
November 2013

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings.

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment.

WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

ICD-10 Compliance Date

The compliance deadline for ICD-10 is **October 1, 2014**. Providers and payers need to communicate regularly. Continue to check CMS website for updated materials.

CMS International Classification of Diseases – 10th Revision (ICD-10) web page
http://www.cms.gov/Medicare/Coding/ICD10/index.html

Revalidation of Medicare Provider Enrollment Information

Section 6401(a) of the Affordable Care Act established the requirement for providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011 are not impacted.

Medicare Contractors will send out revalidation notices to the providers and suppliers by March 2015. Providers and suppliers **must wait to submit revalidation** until after they are asked to do so by their Medicare Contractors.

Get easy access to the revalidation process by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application Using Internet-based PECOS
Do you need to enroll in the Medicare program? Change or add a practice location? Or revalidate? PECOS is the fastest, easiest way to enroll in the Medicare program or update your Medicare enrollment record.

Get easy access to Internet-based PECOS by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Internet-based PECOS Education Available

CMS has available an informative 14 page CMS publication (ICN 903767), entitled ***"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"*** to help you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

CMS has available an informative 12 page CMS publication (ICN 903764), entitled ***"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners"*** to help you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

eNews

WPS Medicare sends out a weekly eNews Listserv on Monday with the most current and vital information Medicare providers need to know. The weekly e-News contains policy updates, all current Medicare information, and changes as they happen. A second eNews is sent out on Wednesday containing educational opportunities. To sign up, visit the WPS Medicare website and click on "e-News" in the upper right corner. We encourage all individuals at provider's office to subscribe, as there are no restrictions on how many individuals can subscribe.

Get easy access to the sign-up website by scanning the Quick Response (QR) code above with your smartphone or visit: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

Electronic Funds Transfer (EFT)

Are you still receiving paper checks? EFT sends your Medicare payments directly to your financial institution, allows faster access to funds, deposits your payments electronically on the next business day and eliminates the risk of Medicare paper checks being lost or stolen.

To set up, please download the authorization agreement for EFT at:
http://www.cms.gov/Medicare/CMS-Forms/CMS-forms/downloads//CMS588.pdf

For EFT assistance you may also call: (866) 734-1522.

Sign up for Medicare Learning Network

The Medicare Learning Network® (MLN) is the brand name for official Centers for Medicare & Medicaid Services' national provider educational products. These products are designed to share up-to-date educational information and accompany the release of new or revised Medicare program policies. These educational tools are available through various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

CMS Secure Net Access Portal (C-SNAP)

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature “Help Center”.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please contact Medicare Customer Service at:
http://www.wpsmedicare.com/contact.shtml

Get easy Access to C-SNAP by scanning the Quick Response (QR) code above with your smartphone or visiting: http://medicareinfo.com

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers’ needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products that inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare & Medicaid Services (CMS) have implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

Place of Service (POS) Coding Instructions - Revised and Clarified

CMS SE1104 revised and clarified POS coding instructions. Instructions are provided regarding the assignment of POS for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. To learn more visit:

Internet - Only Manual (IOM) Publication 100-04, Medicare Claims Process Manual, Chapter 26, Sections 10.5 and 10.6
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

CR7631
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads//R2679CP.pdf

MLN Matters Article (MM7631):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

WPS Medicare Resources Web Page

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Self-service tools are a way for providers to access Medicare information 24 hours a day, 7 days a week, at a time most suitable to their schedule. The tools allow the user quick and easy access to the most current Medicare information.

Visit the WPS Medicare Resource Web Page:
Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/resources/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/resources/

Medicare Remit Easy Print (MREP)

Are you still receiving paper Remit Notices? MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view**.**

Get easy Access to MREP by scanning the Quick Response (QR) code above with your smartphone or visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

CMS Fraud Prevention Training Modules for Providers

To help assist CMS in their efforts to prevent fraud and abuse, CMS created two fraud prevention training modules. Each module provides key information to health care practitioners and professionals on how they can be part of CMS' efforts to fight fraud and abuse.

The first module presents CMS' provider-focused fraud awareness and prevention initiatives that informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module is located at: *http://www.medscape.org/viewarticle/764496*

The second module describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this module is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module is located: *http://www.medscape.org/viewarticle/764791*

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of www.medscape.com.

Instructions for how to access these modules are as follows:

Step 1: Access the website: www.medscape.org. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of www.medscape.org next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: http://www.medscape.org/viewarticle/764496

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: http://www.medscape.org/viewarticle/764791

For assistance, please contact the EDI department at (866) 503-9670

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. Eligible professionals may choose to participate in three payment incentive programs.

1. **Physician Quality Reporting System** – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries.

Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. **Electronic Prescribing (eRX)** – Medicare Eligible Professionals (EPs) who are successful electronic prescribers. An incentive program separate from and in addition to the Physician Quality Reporting System program.

   Find more information on the eRX Incentive Program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Educational_Resources.html

   Negative Payment Adjustment

   The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to apply a negative payment adjustment to any Eligible Professional (EP) who is not a successful e-prescriber under the eRx Incentive Program.

   Effective January 1, 2012, EPs who are not successful electronic prescribers are subject to a negative payment adjustment. An EP receiving the negative payment adjustment would be paid 1% less than the Medicare Physicians Fee Schedule (MPFS) amount for that service. In 2013, the negative payment adjustment increases to 1.5% and in 2014 the negative payment adjustment is 2%.

   CMS Quick Reference Guide for the 2012 eRx Payment Adjustment: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/downloads/QRGuide_understanding_2012eRxPayAdj_F01-09-2012_508.pdf

   Posting the Limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment.
   The hard copy disclosure report will explain the eRx reduced limiting charge by providing the following message: *"Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) incentive Program."*

   MLN Matters Article (MM7877): Posting the limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7877.pdf

3. **Electronic Health Records (EHR)** – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Quality and Resource Use Reports (QRUR)

QRUR reports provide confidential information about the quality of care providers furnish, the resources they use to care for their Medicare-fee-for-service patients and provide comparative information so physicians can see their quality of care compared to physicians / practices in similar specialties.

The Program Year 2011 (PY2011) QRURs were available from late December 2012 - April 2013 to physicians practicing within a group of 25 or more eligible professionals within the nine states of California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska and Wisconsin. The 2011 reports are no longer available.

In mid-September 2013, CMS will make available the PY 2012 QRURs for groups nationally that consist of 25 or more eligible professionals. The implementation of the Value Based Modifier in 2015, will be based on a 2013 performance period and will impact medical practice groups rather than individual physicians. QRURs for individual physicians will not be produced in 2013.

Information regarding the QRUR, value-based modifier and the Physician Feedback Program can be found on the Physician Feedback Program page of the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Email questions about the physician feedback program to QRUR@cms.hhs.gov

CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (http://www.medscape.org/viewarticle/780900?src=cmsaca), and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of http://www.medscape.com

Advance Beneficiary Notice of Noncoverage (ABN), FORM- R-131 Updates

Home Health Agency (HHA): As of December 9, 2013, Home Health Agencies (HHA) are required to use the Advance Beneficiary Notice of Noncoverage (ABN) CMS Form CMS-R-131 in certain situations. The Home Health Advance Beneficiary Notice of Noncoverage (HHABN) CMS Form CMS-R-296 will no longer be recognized for option 1. The CMS Internet-Only

Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.4 gives examples of when an ABN is required and how to complete it for HHAs.

Outpatient Therapy Services:

The American Taxpayer Relief Act (ATRA) provides liability protection for the beneficiary; therefore, providers will be required to give patients an ABN when services are over the Medicare Therapy Cap. CMS suggests using language similar to:

"You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary."

CMS doesn't require an ABN if the therapy service is medically necessary. In such a case, the provider should continue to append the KX modifier on claims submitted.

The CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.5 provides clarification on the use of the ABN for outpatient therapy services.

To find more information on using the ABN form, visit the CMS website:
http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

To Download the CMS-ABN-R-131 form and instructions:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Reference the article Advance Beneficiary Notice of Noncoverage (ABN) found on the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/submission/abn.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/claims/submission/abn.shtml

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Fee Schedule

Announcement regarding 2014 impacted regulations:

http://www.cms.gov/Center/Provider-Type/Physician-Center.html

Enrollment

WPS Medicare article – *Reasonable Charge Locality Pricing for Indiana Services*

http://www.wpsmedicare.com/j8macpartb/departments/enrollment/reasonable-pricing-indiana.shtml

News Web Page

http://www.wpsmedicare.com/j8macpartb/news/index.shtml

Current News

http://www.wpsmedicare.com/j8macpartb/news/current-news/index.shtml

Archived News

http://www.wpsmedicare.com/j8macpartb/news/archived-news/index.shtml

CMS Change Request (CR) 8132, Transmittal 2630

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2630CP.pdf

Opt-out

WPS Medicare article - *Opting Out of Medicare*

http://www.wpsmedicare.com/j8macpartb/departments/enrollment/b_opt_enroll.shtml

Medicare Opt Out Affidavit

http://www.wpsmedicare.com/j8macpartb/forms/provider-enrollment/_files/medicare-opt-out-affidavit.pdf

WPS Medicare Indiana Opt Out List

http://www.wpsmedicare.com/j8macpartb/departments/enrollment/in-opt.shtml

Charging the Medicare Patient

WPS Medicare article – *Medicare Participation Program*

http://wpsmedicare.com/j8macpartb/departments/enrollment/medparticipation.shtml

WPS Medicare article – *Limiting Charge*

http://wpsmedicare.com/j8macpartb/fees/general_fee_info/limitingchrg.shtml

What's New? Announcing the WPS Medicare Website FYI Database and ICD-10 Web Page

FYI Database

http://www.wpsmedicare.com/fyi_database.shtml

ICD-10 Web Page

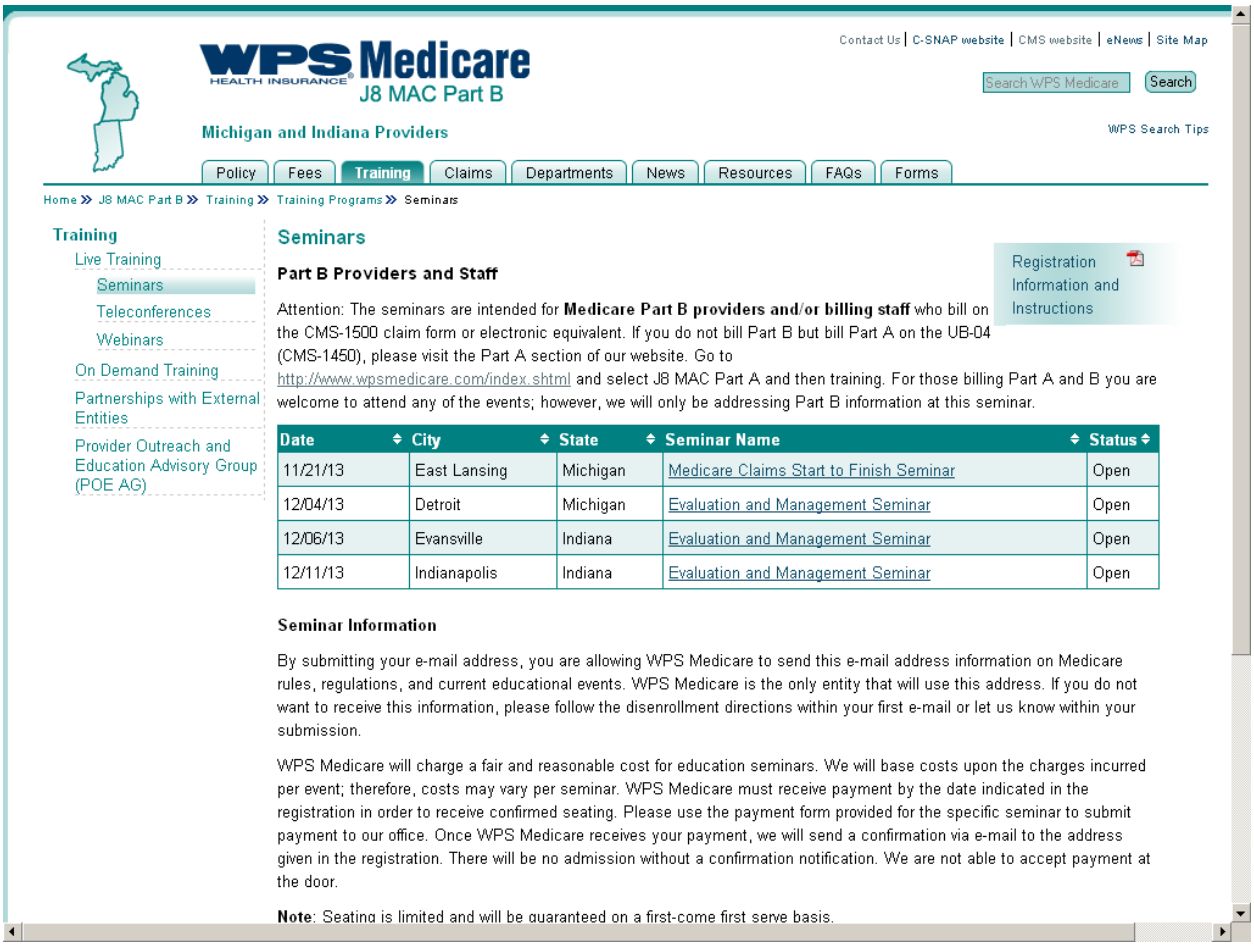
http://www.wpsmedicare.com/j8macpartb/claims/icd-10/index.shtml

CMS Fact Sheet – *Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority*

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Furnished-to-Beneficiaries-in-Custody-Under-Penal-Authority-Fact-Sheet-ICN908084.pdf

Coming soon!

http://www.wpsmedicare.com/j8macpartb/training/training_programs/seminars/



WPS Medicare On Demand Training Web Page

http://www.wpsmedicare.com/j8macpartb/training/on_demand/

November 8, 2013 Medicare Coalition

Fee Schedule

If the final rules are not out by January 1, 2014, will the Medicare payment reflect the 24.4% decrease?

WPS Medicare response: On October 23, 2013, the Centers for Medicare & Medicaid Services (CMS) released the following information:

Although we are still assessing the impact of the partial government shutdown on completion of the calendar year 2014 Medicare fee for service payment regulations, we intend to issue the final rules on or before November 27, 2013, generally to be effective on January 1, 2014.

The impacted regulations include *revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule with Comment Period (CMS-1600-FC).*

Enrollment

1. In a time share location the phone will not be answered per provider. It is not unusual to have a time share location so; when WPS is unable to verify a phone number at a time share location address, how do you get past the phone number issue?

   WPS Medicare response: A letter of explanation and a phone bill, or copy of phone bill, from the provider will assist Provider Enrollment (PE) in meeting this requirement.

2. Why are development letters requesting a copy of a business occupancy license when Indiana does not require a business occupancy license?

   WPS Medicare response: PE is implementing changes in an attempt to remove this from processes.

3. Why would the Medicare Administrative Contractor (MAC) issue an additional Provider Transaction Access Number (PTAN) to an existing tax identification number (TIN) and PTAN due to which location and codes being billed?

   WPS Medicare response: Please refer to WPS Medicare response for #5.

4. Different PTANs mean different claim forms. As an example - fracture care or visit on one claim form but the casting supplies would need to be on a different claim form.

   WPS Medicare response: Please refer to WPS Medicare response for #5.

5. Could WPS please explain the interpretation of “multiple payment localities” in Indiana and the differences in interpretation from one MAC to another?

WPS Medicare response: Provider Outreach & Education (POE) and PE recently collaborated on an article that addresses this. We published the article on the Current News web page (http://www.wpsmedicare.com/j8macpartb/news/current-news/index.shtml) the week of 10/07/2013. The article continues to be available from our Archived News web page, located at (http://www.wpsmedicare.com/j8macpartb/news/archived-news/index.shtml). The article later posted on our Provider Enrollment web page (http://www.wpsmedicare.com/j8macpartb/departments/enrollment/) on Thursday, October 31, 2013.

Reasonable Charge Locality Pricing for Indiana Services

Indiana has only one single payment locality. Why does WPS Medicare issue Provider Transaction Access Numbers (PTANs) for the same provider based on multiple "Reasonable Charge" localities?

*It is a correct statement that Indiana only has one single payment locality; however, CMS has designated a few codes that are priced based on "Reasonable Charge" localities. The latest Change Request (CR) that indicates these codes is CR 8132, Transmittal 2630, (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2630CP.pdf*. When processing claims that include these codes, WPS Medicare will price the service based on the Reasonable Charge locality.*

For this reason, when an existing Indiana group requests an additional practice location be added, WPS Medicare will send a Reasonable Charge Certification letter to the group asking the provider to certify that they do not intend to bill the CMS identified codes that are priced based on the Reasonable Charge locality.

We are unable to comment on how other MACs interpret the CMS published guidance referenced in CR 8132, Transmittal 2630, Effective Date: January 1, 2013, Implementation Dates: January 7, 2013.

WPS Medicare is aware that some Indiana providers contacted the former Indiana carrier and collapsed their PTAN when CMS issued CR 5906, Transmittal 244, Effective Date: January 1, 2008, Implementation Date: April 7, 2008, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R244PI.pdf.

CR 5906 language specifically states that entities that preferred to collapse the group and individual PTANS assigned to additional locations into one PTAN to be used for all

locations **can only be accomplished** if the additional locations are all assigned the same tax identification number (TIN) and **are within the same pricing locality**.

Opt-out

If a physician has never enrolled in Medicare and wants to see the Medicare patient with private contract is there any way to opt-out without enrolling first?

WPS Medicare response: In order to opt out of Medicare, a provider need not initially enroll, however, the provider must file a valid opt out affidavit with the WPS Provider Enrollment Department no later than ten days after the first private contract is entered into with a Medicare beneficiary. The form is available on our website at http://wpsmedicare.com/j8macpartb/forms/provider-enrollment/_files/medicare-opt-out-affidavit.pdf

For additional details, including an overview, private contracts, opt out affidavits, renewal of opt out, early termination of opt out, listings of specialties that may/may not opt out of Medicare, and more, please visit our Opting out of Medicare web page at http://wpsmedicare.com/j8macpartb/departments/enrollment/b_opt_enroll.shtml

Charging the Medicare Patient

Where can you find the statement "you can never charge a Medicare patient more than another patient"? It is known this can be done when there is another insurance company involved and the physician has a contractual obligation with the other company; however this is being requested in writing.

WPS Medicare response: While the following response does not include the specific verbiage you are seeking, it does reflect Medicare rules for the two types of Part B providers; participating and nonparticipating.

Participating "Par" Providers and Suppliers

Providers who choose to participate in Medicare agree to accept the Medicare participating fee allowance as the payment in full. One advantage of participation is that the provider can still bill his/her standard fee to Medicare, alleviating the need for different amounts in his/her computer billing system. Medicare will approve the par fee allowance, knowing the provider has agreed to accept this amount, and there is no penalty to him/her. Any difference between the standard full fee and the participating fee allowance will be "written off."

Nonparticipating "Nonpar" Providers and Suppliers

The nonparticipating fee allowance is 95% of the participating fee allowance. When a provider chooses not to participate in Medicare, he/she can choose to accept assignment on a case by case basis. If the provider chooses not to accept assignment on a claim, Medicare will make payment directly to the beneficiary and the provider may bill no more than the "limiting charge." If a nonparticipating provider accepts assignment, he/she must accept the non-par fee allowance as payment in full.

Limiting Charge

This charge is the amount that nonparticipating providers are “limited” to charge for that service. The amount is 115% of the non-par fee allowance. This applies only to nonparticipating providers. You may never charge a Medicare patient more than this amount for any reimbursable Medicare service. If you send higher amounts into Medicare, they will appear on a Medicare Limiting Charge Exception Report (LCER) and reflect negatively on you. One exception to this rule exists, however: you are allowed to round the limiting charge to the nearest dollar without penalty, as long as you round consistently.