CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1725	**Date: May 1, 2009**
	Change Request 6303

SUBJECT: Requirements for Specialty Codes

I. SUMMARY OF CHANGES: This Change Request changes the criteria for acceptance or denial of requests for specialty codes.

New / Revised Material
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.8/Requirements for Specialty Codes

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1725	Date: May 1, 2009	Change Request: 6303

SUBJECT: Requirements for Specialty Codes

Effective Date: July 1, 2009

Implementation Date: July 6, 2009

I. GENERAL INFORMATION

A. Background: Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on their Medicare enrollment application (CMS-855I) or on the Internet-based Provider Enrollment, Chain and Ownership System. Non-physician practitioners are assigned a Medicare specialty code when they enroll based on their profession. Specialty codes are used by CMS for programmatic and claims processing purposes.

B. Policy: This Change Request revises Pub. 100-04, chapter 26, section 10.8. The CMS will consider certain criteria for approving or disapproving requests from physician specialty associations for inclusion in the list of Medicare physician/non-physician practitioner specialty codes. Medicare contractors shall not add any specialty codes to the list. They must send all requests for expansion of the specialty code list to the Director of the Division of Practitioner Services, Centers for Medicare & Medicaid Services, Mail Stop C4-01-26, 7500 Security Blvd., Baltimore, MD 21244.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6303.1	Medicare contractors shall not add any specialty codes to the list of Medicare physician/non-physician practitioner specialty codes.	X			X						
6303.1.1	The contractor shall forward any requests they receive to the Director, Division of Practitioner Services, Centers for Medicare and Medicaid Services, Mail Stop C4-01-26, 7500 Security Blvd., Baltimore, MD 21244.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6303.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Stephanie Monroe (410) 786-6864

Post-Implementation Contact(s): Stephanie Monroe (410) 786-6864

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs),*** **use the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.8 - Requirements for Specialty Codes

(Rev.1725, Issued: 05-01-09, Effective: 07-01-09, Implementation: 07-06-09)

Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on their Medicare enrollment application (CMS-855I) or on the Internet-based Provider Enrollment, Chain and Ownership System. Non-physician practitioners are assigned a Medicare specialty code when they enroll based on their profession. Specialty codes are used by CMS for programmatic and claims processing purposes.

A. A physician specialty association will submit *a* specialty code *request to the Director, Division of Practitioner Services, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail Stop C4-01-26, 7500 Security Blvd., Baltimore, MD 21244.*

Medicare contractors shall not add any specialty codes to the list. They *must* send all requests for expansion of the *specialty code* list to the *Director, Division of Practitioner Services, at the address above.*

B. When considering a request for expanding the specialty code list for physician and non-physician practitioners, CMS will take into consideration the following:

- Whether *the requested specialty* has the authority to bill *Medicare* independently;
- The *requester's stated* reason or purpose for the code;
- *Evidence that the practice pattern of the specialty is markedly different from that of the dominant parent specialty;*
- *Evidence of any specialized training and/or certification required;*
- *Whether the specialty treats a significant volume of the Medicare population;*
- Whether *the specialty is* recognized by another organization, such as the American Board of Medical Specialties; and
- *Whether the specialty has a corresponding Healthcare Provider Taxonomy Code.*

Physicians *may not have* a specialty code *of* 70 (single or multi-specialty Clinic or Group Practice.) Contractors must contact physicians *whose records indicate* specialty *code* 70 and *require the physicians to update their enrollment records by submitting a CMS-8551 with a specialty that is valid for a physician.*