CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 195	Date: MARCH 30, 2007
	Change Request 5503

SUBJECT: General Background Information on Individual Practitioners and Certain Part B Services

I. SUMMARY OF CHANGES: This change request updates Pub. 100-08, chapter 10, section 12, with background information on various types of individual practitioners and Part B services.

NEW / REVISED MATERIAL
EFFECTIVE DATE: April 30, 2007
IMPLEMENTATION DATE: April 30, 2007

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	10/Table of Contents
N	10/6.2.1/Suppliers Not Eligible to Participate
N	10/12.4/Individual Practitioners
N	10/12.4.1/Anesthesiology Assistants
N	10/12.4.2/Audiologists
N	10/12.4.3/Certified Nurse-Midwives
N	10/12.4.4/Certified Registered Nurse Anesthetists
N	10/12.4.5/Clinical Nurse Specialists (CNS)
N	10/12.4.6/Clinical Psychologists
N	10/12.4.7/Clinical Social Workers
N	10/12.4.8/Nurse Practitioners
N	10/12.4.9/Occupational and Physicial Therapists in Private Practice
N	10/12.4.10/Physician Assistants (PA)
N	10/12.4.11/Psychologists Practicing Independently
N	10/12.4.12/Registered Dietitians

N	10/12.5.1/Other Part B Services
N	10/12.5.2/Diabetes Self-Management Training (DSMT)
N	10/12.5.3/Mass Immunizers Who Roster Bill

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 195	Date: March 30, 2007	Change Request: 5503

SUBJECT: General Background Information on Individual Practitioners and Certain Part B Services

Effective Date: April 30, 2007

Implementation Date: April 30, 2007

I. GENERAL INFORMATION

A. Background: This change request updates Pub. 100-08, chapter 10, section 12, with background information on various types of individual practitioners and Part B services.

B. Policy: These revisions to section 12 are designed to help contractor personnel - especially new employees - gain a better understanding of the types of suppliers that enroll in the Medicare program.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5503.1	If the contractor receives a Form CMS-855 application from a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) that would like to bill for Diabetes Self-Management Training (DSMT) services, the contractor shall verify with the National Supplier Clearinghouse (NSC) that the applicant is currently enrolled and eligible to bill the Medicare program.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

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.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.

Post-Implementation Contact(s): Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.

VI. FUNDING

A. ***For TITLE XVIII Contractors*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Program Integrity Manual
Chapter 10 - Medicare Provider Enrollment

Table of Contents
(Rev.195, 03-30-07)

6.2.1 - Suppliers Not Eligible to Participate

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

The following is a list of suppliers who frequently attempt to enroll in Medicare but are not eligible to do so; no statute permits them to bill Medicare. Note that this list is not exhaustive.

If the contractor receives an enrollment application with one of the following types listed thereon, the contractor shall deny the application without development.

- *Acupuncturist*
- *Assisted Living Facilities*
- *Birthing Centers*
- *Certified Alcohol and Drug Counselor*
- *Certified Social Worker*
- *Drug and Alcohol Rehabilitation Counselor*
- *Hearing Aid Center/Dealer*
- *Licensed Alcoholic and Drug Counselor*
- *Licensed Massage Therapist (LMT)*
- *Licensed Practical Nurse (LPN)*
- *Licensed Professional Counselor*
- *Marriage Family Therapist (MFT)*
- *Masters of Social Work*
- *Mental Health Counselor*
- *National Certified Counselor*
- *Registered Nurse*
- *Speech and Hearing Center*
- *Speech Language Pathologist*
- *Substance Abuse Facility*

12.4 - Individual Practitioners
(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

This section furnishes background information on certain types of non-physician practitioners (NPPs). While Medicare has established Federal standards governing these supplier types, these practitioners must also comply with all applicable State and local laws as a precondition of enrollment.

The qualifications listed below for each NPP type – whether they were quoted from the applicable regulation or the appropriate manual instruction – represent current CMS policy.

12.4.1 - Anesthesiology Assistants
(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

As stated in Pub. 100-04, chapter 12, section 140.1, an anesthesiology assistant is a person who:

- *Is permitted by State law to administer anesthesia; and*
- *Has successfully completed a 6-year program for anesthesiology assistants, of which 2 years consists of specialized academic and clinical training in anesthesia.*

For more information on anesthesiology assistants, refer to:

- *Section 1861(bb)(2) of the Social Security Act*
- *42 CFR §410.69(b)*
- *Pub. 100-04, chapter 12, sections 140 – 140.4.4 (Claims Processing Manual)*

12.4.2 - Audiologists
(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Under 42 CFR §440.110(c)(3), a "qualified audiologist" is an individual who:

- *Has a master's or doctoral degree in audiology; and*
- *Is licensed as an audiologist by the State in which the individual furnishes such services and that State's requirements meet or exceed those in 42 CFR §440.110(c)(3)(ii)(A) or 42 CFR §440.110(c)(3)(ii)(B) (both of which are identified below).*

If the person: (1) furnishes audiology services in a State that does not license audiologists, or (2) is exempted from State licensure based on practice in a specific institution or setting, the person must meet one of the following conditions:

- *Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association. (42 CFR §440.110(c)(3)(ii)(A))*

OR

- *Successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); and*

- *Performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and*

- *Successfully completed a national examination in audiology approved by the Secretary. (42 CFR §440.110(c)(3)(ii)(B))*

Thus, if the individual does not have a State license for either of the reasons stated in 42 CFR §440.110(c)(3)(ii), the person must meet the certification requirement in 42 CFR §440.110(c)(3)(ii)(A), OR <u>all three</u> of the criteria listed in 42 CFR §440.110(c)(3)(ii)(B), in order to be eligible to enroll in Medicare.

For more information on audiologists, refer to:

- *Section 1861(ll)(3)(B) of the Social Security Act*

- *Pub. 100-02, chapter 15, sections 80.3 and 80.3.1(Benefit Policy Manual)*

12.4.3 - Certified Nurse-Midwives

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

As stated in Pub. 100-02, chapter 15, section 180, a certified nurse-midwife must:

(1) Be currently licensed to practice in the State as a registered professional nurse; and

(2) Meet one of the following requirements:

a. Be legally authorized under State law or regulations to practice as a nurse-midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the State; OR

b. If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, the individual must:

1. Be currently certified as a nurse-midwife by the American College of Nurse-Midwives; or

2. Have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or

3. Have successfully completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.

All certified nurse-midwives, therefore, must: (1) be State-licensed as a registered nurse in the State in which the person seeks to practice as a nurse-midwife, (2) be legally authorized by the State to practice as a nurse-midwife, and (3) have completed a State-specified program of study and clinical experience for nurse-midwives. If the State does not specify such a program of study and clinical experience, the individual must meet one of the three criteria in 2(b) above.

For more information on certified nurse midwives, refer to:

- *Section 1861(gg) of the Social Security Act*
- *42 CFR §410.77*
- *Pub. 100-04, chapter 12, section 130 – 130.2 (Claims Processing Manual)*

12.4.4 - Certified Registered Nurse Anesthetists (CRNAs)

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

As stated in Pub. 100-04, chapter 12, section 140.1, a certified registered nurse anesthetist (CRNA) is a registered nurse who is licensed as such by the State in which the nurse practices and who:

- *Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or*
- *Has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.*

For more information on CRNAs, refer to:

- *Section 1861(bb) of the Social Security Act*
- *42 CFR §410.69(b)*
- *Pub. 100-04, chapter 12, sections 140 through 140.4.4 (Claims Processing Manual)*

12.4.5 - Clinical Nurse Specialists (CNS)

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Per Pub. 100-02, chapter 15, section 210, a clinical nurse specialist must:

- *Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;*
- *Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and*
- *Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.*

Under 42 CFR §410.76(c)(3), clinical nurse services are covered only if, among other things, the CNS performed them while working in collaboration with a physician. Collaboration is a process in which a CNS works with one or more physicians to deliver health care services within the scope of the CNS's professional expertise, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished.

- *For more information on clinical nurse specialists, refer to:*
- *42 CFR §410.76*
- *Pub. 100-04, chapter 12, sections 120 and 120.1 (Claims Processing Manual)*

12.4.6 - Clinical Psychologists

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Under 42CFR §410.71(d), to qualify as a clinical psychologist a practitioner must meet the following requirements:

- *Hold a doctoral degree in psychology; and*

- *Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.*

A clinical psychologist must agree to meet the consultation requirements of 42 CFR §410.71(e)(1) through (e)(3). Under 42 CFR §410.71(e), the practitioner's signature on the Form CMS-855I indicates his or her agreement.

For more information on clinical psychologists, refer to:

- *Pub. 100-04, chapter 12, sections 170 (Claims Processing Manual)*

- *Pub. 100-02, chapter 15, section 160 (Benefit Policy Manual).*

12.4.7 - Clinical Social Workers

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Under 42 CFR §410.73(a), to qualify as a clinical social worker a practitioner must meet the following requirements:

1. Possesses a master's or doctor's degree in social work;

2. After obtaining the degree, has performed at least 2 years of supervised clinical social work; and

3. Either is licensed or certified as a clinical social worker by the State in which the services are performed or, in the case of an individual in a State that does not provide for licensure or certification as a clinical social worker—

a. Is licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and

b. Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting, such as a hospital, SNF, or clinic.

For more information on clinical social workers, refer to:

- *Section 1861(hh) of the Social Security Act*

- *Pub. 100-02, chapter 15, section 170 (Benefit Policy Manual)*

- *Pub. 100-04, chapter 12, section 150 (Claims Processing Manual)*

12.4.8 - Nurse Practitioners

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Under 42 CFR §410.75(b), in order to bill Medicare a nurse practitioner must meet the following conditions:

- *Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or*

- *Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.*

Nurse practitioners applying for a Medicare billing number for the first time on or after January 1, 2001, must meet the following requirements:

- *Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and*

- *Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.*

Nurse practitioners applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the following requirements:

- *Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and*

- *Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and*

- *Possess a master's degree in nursing.*

Thus, any nurse practitioner applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the post-January 1, 2003 requirements.

As stated in Pub. 100-02, chapter 15, section 200, the following organizations are recognized national certifying bodies:

- *American Academy of Nurse Practitioners;*
- *American Nurses Credentialing Center;*
- *National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;*
- *National Certification Board of Pediatric Nurse Practitioners and Nurses;*
- *Oncology Nurses Certification Corporation; and*
- *Critical Care Certification Corporation.*

In addition, under 42 CFR §410.75(c)(3) nurse practitioner services are covered only if, among other things, the nurse practitioner performed them while working in collaboration with a physician. Collaboration is a process in which a nurse practitioner works with one or more physicians to deliver health care services within the scope of the nurse practitioner's professional expertise, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished.

For more information on nurse practitioners, refer to:

- *Pub. 100-02, chapter 15, section 200 (Benefit Policy Manual)*
- *Pub. 100-04, chapter 12, sections 120 and 120.1 (Claims Processing Manual)*

12.4.9 - Occupational and Physical Therapists in Private Practice

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

A. Occupational Therapists (OTs)

As stated in Pub. 100-02, chapter 15, section 230.2(B), a qualified occupational therapist for program coverage purposes is an individual who meets one of the following requirements:

- *Is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education of the American Medical Association and the American Occupational Therapy Association;*
- *Is eligible for the National Registration Examination of the American Occupational Therapy Association; or*
- *Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977.*

B. Physical Therapists (PTs)

As stated in Pub. 100-02, chapter 15, section 230.1(B), a qualified physical therapist for program coverage purposes is a person who is licensed as a physical therapist by the state in which he or she is practicing and meets one of the following requirements:

- *Has graduated from a physical therapy curriculum approved by (1) the American Physical Therapy Association, or by (2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or (3) Council on Medical Education of the American Medical Association, and the American Physical Therapy Association; or*

- *Prior to January 1, 1966, (1) was admitted to membership by the American Physical Therapy Association, or (2) was admitted to registration by the American Registry of Physical Therapists, or (3) has graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education; or*

- *Has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking qualification as a physical therapist after December 31, 1977; or*

- *Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or*

- *If trained outside the United States, (1) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, (2) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.*

For more information on physical and occupational therapists, refer to:

- *42 CFR §410.59(c) (occupational therapists)*

- *42 CFR §410.60(c) (physical therapists)*

- *Pub. 100-02, chapter 15, sections 230.2 and 230.4 (Benefit Policy Manual) (occupational therapists)*

- *Pub. 100-02, chapter 15, sections 230.1 and 230.4 (Benefit Policy Manual) (physical therapists)*

- *Sections 4.2.6 and 4.2.7(H) of chapter 10 of this manual*

12.4.10 - Physician Assistants (PA)

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

As stated in Pub. 100-02, chapter 15, section 190, a physician assistant (PA) must meet the following Medicare requirements:

1. Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or

2. Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and

3. Be licensed by the State to practice as a physician assistant.

As indicated in Pub. 100-02, chapter 15, section 190(D):

- *Payment for the PA's services may only be made to the PA's employer, not to the PA himself/herself. In other words, the PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not reassign his or her benefits to the employer, since the employer must receive direct payment anyway.*

- *The PA's employer can be either an individual or an organization. If the employer is a professional corporation or other duly qualified legal entity (e.g., LLC, LLP) in a State that permits PA ownership in the entity (e.g., as a stockholder, member), the entity may bill for PA services even if a PA is a stockholder or officer of the entity – so long as the entity is eligible to enroll as a provider or supplier in the Medicare program. PAs may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to, sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. Moreover, leasing agencies and staffing companies do not qualify under the Medicare program as "providers of services" or suppliers of services.*

For more information on physician assistants, refer to:

- *42 CFR §410.74*

- *Pub. 100-04, chapter 12, sections 110 through 110.3 (Claims Processing Manual)*

12.4.11 - Psychologists Practicing Independently
(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

As stated in Pub. 100-02, chapter 15, section 80.2, a psychologist practices independently when:

- *They render services on their own responsibility, free of the administrative and professional control of an employer such as a physician, institution or agency;*

- *The persons they treat are their own patients;*

- *They have the right to bill directly, collect and retain the fee for their services; and*

- *The psychologist is State-licensed or certified.*

A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions exist:

- *The office is confined to a separately-identified part of the facility which is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and*

- *The psychologist conducts a private practice (i.e., services are rendered to patients from outside the institution as well as to institutional patients).*

The key distinction between independently practicing psychologists and clinical psychologists is that the latter requires a doctoral degree and has certain consultation requirements.

For more information on independently practicing psychologists, refer to:

- *Section 4.2.7 of this manual*

- *Pub. 100-04, chapter 12, sections 160 and 160.1 (Claims Processing Manual)*

12.4.12 - Registered Dietitians
(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

Per 42 CFR §410.134, a registered dietitian (or nutrition professional) means an individual who, on or after December 22, 2000:

1. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the

academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose;

2. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

3. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian"' by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (A) and (B) above.

There are two caveats to these requirements:

- *A dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements of A and B above.*

- *A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of A and B above.*

For more information on registered dietitians, refer to:

- *Sections 1861(vv) of the Social Security Act*

- *42 CFR §410.130 through § 410.134*

12.5.1 - Other Part B Services

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

12.5.2 - Diabetes Self-Management Training (DSMT)

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

A. General Background Information

The DSMT is not a separately recognized provider type like a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. Rather, DSMT is merely an extra service that a currently-enrolled provider or supplier can bill for, assuming it meets all of the necessary DSMT requirements.

All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA) and the Indian Health Service as approved national

accreditation organizations. A Medicare-enrolled provider or non-DMEPOS supplier that wishes to bill for DSMT may simply submit the ADA certificate to its contractor. No Form CMS-855 paperwork is required, unless the provider or supplier is not in PECOS, in which case - per section 7.1.1 of this manual – a complete Form CMS-855 application is required.

If the supplier is exclusively a DMEPOS supplier, it must complete and submit a Form CMS-855B application to its local carrier. This is because DMERCs do not pay DSMT claims, but carriers can. Thus, the DMEPOS supplier must separately enroll with its carrier, even if it has already completed a Form CMS-855S. If a carrier receives an application from a DMEPOS supplier that would like to bill for DMST, it shall verify with the National Supplier Clearinghouse that the applicant is currently enrolled and eligible to bill the Medicare program.

For more information on DSMT, refer to:

- *Section 1861(qq) of the Social Security Act*
- *42 CFR Part 410 (subpart H)*
- *Pub. 100-02, chapter 15, sections 300 – 300.5.1 (Benefit Policy Manual)*

12.5.3 - Mass Immunizers Who Roster Bill

(Rev.195, Issued: 03-30-07, Effective: 04-30-07, Implementation: 04-30-07)

An entity or individual who wishes to furnish mass immunization services, but may not otherwise qualify as a Medicare provider, may be eligible to enroll as a "Mass Immunizer" via the Form CMS-855I (individuals) or the Form CMS-855B (entities). Such providers, among other things, must meet the following requirements:

- *They may not bill Medicare for any services other than pneumococcal pneumonia vaccines (PPVs), influenza virus vaccines, and their administration.*
- *They must submit claims through the roster billing process.*
- *All personnel who administer the shots must meet all applicable State and local licensure or certification requirements.*

The roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by public health clinics and other organizations and persons who give the vaccine to a group of beneficiaries at sites such as clinics, shopping malls, grocery stores, senior citizen homes, and health fairs.

For more information on mass immunization roster billing, refer to:

- *Pub. 100-02, chapter 15, section 50.4.4.2 (Benefit Policy Manual)*

- *Pub. 100-04, chapter 18, sections 10 through 10.3.2.3 (Claims Processing Manual) (**NOTE:** Section 10.3.1 outlines the requirements for submitting roster bills.)*