CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 304	**Date: April 27, 2018**
	Change Request 10457

SUBJECT: New Physician Specialty Code for Medical Genetics and Genomics

I. SUMMARY OF CHANGES: The Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Medical Genetics and Genomics (D3).

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/150/Part D(1) - Claims Processing Timeliness - All Claims
R	6/170.3/Part E - Interest Payment Data
R	6/260.1/Classification of Claims for Counting
R	6/400.4/Physician/Limited License Physician Specialty Codes
R	6/420/Exhibit

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 304	Date: April 27, 2018	Change Request: 10457

SUBJECT: New Physician Specialty Code for Medical Genetics and Genomics

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

I. GENERAL INFORMATION

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

B. Policy: The CMS has established a new physician specialty code for Medical Genetics and Genomics (D3).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10457 - 06.1	Contractors shall include physician specialty code Medical Genetics and Genomics (D3) with their submission for CROWD Form “F” (Participating Physician/Supplier Report), in accordance with Publication 100-06, Chapter 6.		X				X			CROWD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10457 - 06.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Gale Johnson, 410-786-2192 or gale.johnson@cms.hhs.gov , Alisha Sanders, 410-786-0671 or alisha.sanders@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

150 - Part D(1) - Claims Processing Timeliness - All Claims

(Rev.304, Issued: 04-27-18, Effective: 10-01-18, Implementation: 10- 01-18)

Pages 2-9 of the CMS-1565 include data on its activity in processing all claims to completion during the reporting period. A claim is counted as processed to completion on the scheduled payment date, which is the date the check is mailed, deposited in the provider's account, or transferred electronically. For non-paid claims, the date of completion is the date the MSN or other notice of final action on the claim is mailed. Data shown must be based on reliable counts of all claims (real and replicate) processing activity. The A/B MAC (B) does not estimate claim counts. It reports only data relating to initial claims (real and replicate) actions. It does not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

"Clean" claims are defined as those that do not require investigation or development external to the A/B MAC (B)'s operation on a prepayment basis. Claims which do not meet the definition of "clean" are "other" claims. Claims paid are those for which some payment was made (i.e., payment greater than zero). Claims not paid are those for which no payment was made (i.e., claim charges applied completely toward deductible or fully denied).

On pages 2-9, the A/B MAC (B) reports:

- In column 1, the total number of claims processed to completion;
- In column 2, the number of "clean" claims paid;
- In column 3, the number of "other" claims paid;
- In column 4, the number of "clean" claims not paid;
- In column 5, the number of "other" claims not paid; and
- In column 6, the number of "clean" or "other" claims processed to completion, which were received via electronic media from providers or their billing agencies and read directly into the A/B MAC (B)'s claims processing system. The A/B MAC (B) does not count on this line claims that it received in hardcopy and entered using an OCR device. It does not count any claims received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

The data in lines 1 through 37 of pages 2 through 9 represent the number of claims processed in the number of days shown on that line, counting from the date of receipt. Line 38 represents the sum of lines 1-37. The date of receipt is defined for hard-copy and magnetic tape claims as the date of receipt in the mailroom. For EMC billed via terminal or equivalent, it is the date the claim passes all front-end edits. For split claims, whether required or replicate, the date of receipt is the date of receipt of the original claim material, not the date of the split.

To calculate the processing time for a claim, the A/B MAC (B) subtracts the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, it adds 365 to the Julian date of completion (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is 1 day. This definition applies to all lines of the report, including line 39.

On line 39, the A/B MAC (B) reports the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, it adds the processing times for the claims shown in line 38 of that column, and divides by the number in line 38. It does not use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 34-37, it uses the processing times for individual claims, as explained below, to make this calculation.

Mean PT Calculation for All Claims - To determine the mean PT for all claims:

- Subtract the Julian date of receipt from the Julian date of payment or equivalent action for those not paid for each claim.

- Accumulate the result to cell counter for number of days for all claims.
- Divide this result by the total number of claims.
- Round to one decimal place.

EXAMPLE:

Claim	Julian Date Receipt	Paid	Counter by Days	Counter by Claims
A	87103	87133	30	1
B	87105	87206	101	2
C	87115	87177	62	3
D	87120	87213	93	4
E	87122	87215	93	5
F	87130	87223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472
Mean = 472/6 = 78.6666 = 78.7
The A/B MAC (B) completes the report for each of the following claim types:

Page 2. Assigned Physician - It shows the number of assigned claims included on page 9 which involved services billed by physicians. Physicians are identified by specialty codes 01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98, 99, C0, or C3, C5, C6, C7, C8, C9*, or D3*.

Page 3. Assigned DME - It shows the number of assigned claims included on page 9 which involved services billed by DME suppliers.

Page 4. Assigned Lab - It shows the number of assigned claims included on page 9 which involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Page 5. Assigned Ambulance - It shows the number of assigned claims included on page 9 which involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Page 6. Assigned Other - It shows the number of assigned non-physician claims included on page 9 but not represented on pages 3, 4, or 5.

Page 7. Unassigned - It shows the number of unassigned claims (real and replicate) included on page 9.

Page 8. Participating Physician - It shows the number of claims included on page 9 involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

Page 9. All Claims - It shows the total number of claims (real and replicate) processed during the month.

170.3 - Part E - Interest Payment Data

(Rev.304, Issued: 04-27-18, Effective: 10-01-18, Implementation: 10- 01-18)

The A/B MAC (B) reports on Page 12 of the CMS-1565 data on the claims on which it paid interest because it paid the claims after the required payment date per §9311 of the Omnibus Reconciliation Act of 1986 (OBRA 1986). It bases data shown on reliable counts of all claims processing activity, not on estimates. It reports data on initial claims only. It includes in the report all claims requiring interest payments in the month. It reports claims in the month the date of payment falls. (For a discussion of interest payments refer to the Medicare Claims Processing Manual, Publication 100-04, chapter 1, sections 80.2.2 and 80.2.2.1).

The A/B MAC (B) completes the report for each column as follows:

Column 1.	Total - Data for all claims (real and replicate) for which interest payments were made during the month.
Column 2.	Assigned Physician - Data for the assigned claims included in column 1 which involved services billed by physicians. Physicians are identified by specialty codes 01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98, 99, C0, C3, C5, C6, C7, C8, C9, *or D3*.
Column 3.	Assigned DME - Data for the assigned claims included in column 1 that involved services billed by DME suppliers.
Column 4.	Assigned Lab - Data for the assigned claims included in column 1 that involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.
Column 5.	Assigned Ambulance - Data for the assigned claims included in column 1 that involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.
Column 6.	Assigned Other - Data for the assigned non-physician claims included in column 1 but not represented in columns 3, 4, or 5.
Column 7.	Unassigned - Data for the unassigned claims included in column 1.
Column 8.	Participating Physician - Data for claims involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

On line 1, the A/B MAC (B) shows the number of claims on which it paid interest in the reporting month. It reports on line 2 the number of claims included in line 1 for which it made payment 1 day after the required payment date (e.g., the required payment date is 17 days after receipt for participating physician claims received in FY 1992.) (See §9311 of OBRA 1986.) Data for lines 3-10 are similar to those for line 2.

The A/B MAC (B) calculates the number of days late by subtracting the Julian date of the required payment date from the Julian date of payment.

On line 11, it shows the amount paid in interest for claims reported in line 1. On lines 12-20, it shows the amount paid in interest for claims reported in lines 2-10, respectively. It shows dollar amounts on lines 11-20 to the nearest penny, and includes the decimal point.

260.1 - Classification of Claims for Counting

(Rev.304, Issued: 04-27-18, Effective: 10-01-18, Implementation: 10- 01-18)

All claims data entered on the CMS-1565C must represent counts of claims (real and replicate) as defined in Pub. 100-04, Medicare Claims Processing Manual, chapter 1, section 70. The A/B MAC (B) classifies the claims on the report form as follows: (1) An assigned claim submitted by a non-participating physician or supplier; (2) An unassigned claim, usually submitted by a beneficiary and accompanied by bills from one or more physicians or suppliers; or (3) A claim submitted by a participating physician or supplier.

The terms "participating" and "non-participating" refer to whether or not the physician/supplier has signed an agreement to follow the provisions of the Medicare Physician/Supplier Participation Program. The A/B MAC (B) classifies claims as follows:

- A claim in which all services were provided when the physician/supplier was "participating" as a participant claim, and

- A claim with a mix of participant and non-participant services (including those cases where a physician/supplier has changed status) as a participant claim.

NOTES: An exception to the above is the unassigned claim involving services by a participating physician/supplier. If the A/B MAC (B) denies this type of claim, it classifies it as a non-

participant, unassigned claim. When the corresponding claim is submitted by the beneficiary's physician (supplier), it classifies it as a participant claim.

The above classification rules apply only to claims. Services, covered charges, and disallowed charges should be allocated according to the participation status of the physician/supplier at the time the service was provided.

The A/B MAC (B) makes the distinction between physician and non-physician claims and services according to the coding used for the Bill Summary Record. It classifies those entities with specialty codes of 01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98, 99, C0, or C3, C5, C6, C7, C8, C9, *or D3* as physicians. It considers all others to be non-physicians.

400.4 - Physician/Limited License Physician Specialty Codes

(Rev.304, Issued: 04-27-18, Effective: 10-01-18, Implementation: 10- 01-18)

The following list of codes and narrative describe the kind of medicine physicians practice.

Code	Physician/Limited License Physician (LLP) Specialty Codes
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Medicine
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists only) (LLP)
20	Orthopedic Surgery
21	Cardiac Electrophysiology
22	Pathology
23	Sports Medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery (formerly Proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic (LLP)
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology

Code	Physician/Limited License Physician (LLP) Specialty Codes
40	Hand Surgery
41	Optometry (LLP)
44	Infectious Disease
46	Endocrinology
48	Podiatry (LLP)
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivist)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery (LLP)
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty
C0	Sleep Medicine
C3	Interventional Cardiology
C5	Dentist
C6	Hospitalist
C7	Advanced Heart Failure and Transplant Cardiology
C8	Medical Toxicology
C9	Hematopoietic Cell Transplantation and Cellular Therapy
D3	*Medical Genetics and Genomics*

NOTE: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".

420 - Exhibit

(Rev.304, Issued: 04-27-18, Effective: 10-01-18, Implementation: 10- 01-18)

Exhibit - Participating Physician/Supplier Report - Screen 1

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology

07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine

	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
SPECIALTY CODE/GROUP	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
01-PHY								
02-PHY								
03-PHY								
04-PHY								
05-PHY								
06-PHY								
07-PHY								
08-PHY								
09-PHY								
10-PHY								
11-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 2

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

12 Osteopathic Manipulative Medicine
13 Neurology
14 Neurosurgery
15 Speech Language Pathologist in Private Practice
16 Obstetrics/Gynecology
17 Hospice and Palliative Care
18 Ophthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
21 Cardiac Electrophysiology
22 Pathology
23 Sports Medicine
24 Plastic and Reconstructive Surgery

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
12-PHY								
13-PHY								
14-PHY								
15-NPP								
16-PHY								
17-PHY								
18-PHY								
19-LLP								
20-PHY								
21-PHY								
22-PHY								
23-PHY								
24-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 3

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

25 Physical Medicine and Rehabilitation
26 Psychiatry
27 Geriatric Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
31 Intensive Cardiac Rehabilitation (ICR)
32 Anesthesiologist Assistant
33 Thoracic Surgery
34 Urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
25-PHY								
26-PHY								
27-PHY								
28-PHY								
29-PHY								
30-PHY								
31-SUP								
32-NPP								
33-PHY								
34-PHY								
35-LLP								
36-PHY								
37-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 4

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetist (CRNA)
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facility (DTL)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
38-PHY								
39-PHY								
40-PHY								
41-LLP								
42-NPP								
43-NPP								
44-PHY								
45-SUP								
46-PHY								
47-SUP								
48-LLP								
49-SUP								
50-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 5

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

59 Ambulance Service Supplier
60 Public Health/Welfare Agency
61 Volunteer Health/Charitable Agency
62 Psychologist (Billing Independently)
63 Portable X-Ray Supplier (Billing Independently)
64 Audiologist (Billing Independently)
65 Physical Therapist in Private Practice
66 Rheumatology
67 Occupational Therapist in Private Practice
68 Clinical Psychologist
69 Clinical Laboratory (Billing Independently.)
70 Single or Multispecialty Clinic or Group Practice
71 Registered Dietitian/Nutrition Professional

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
59-SUP								
60-SUP								
61-SUP								
62-NPP								
63-SUP								
64-NPP								
65-NPP								
66-PHY								
67-NPP								
68-NPP								
69-SUP								
70-PHY								
71-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 6

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

72 Pain Management
73 Mass Immunization Roster Biller
74 Radiation Therapy Centers
75 Slide Preparation Facilities
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivist)
82 Hematology
83 Hematology/Oncology
84 Preventative Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
72-PHY								
73-SUP								
74-SUP								
75-SUP								
76-PHY								
77-PHY								
78-PHY								
79-PHY								
80-NPP								
81-PHY								
82-PHY								
83-PHY								
84-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 7

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

85 Maxillofacial Surgery
86 Neuropsychiatry
88 Unknown Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Unknown Supplier
97 Physician Assistant
98 Gynecological Oncology
99 Unknown Physician Specialty

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
85-LLP								
86-PHY								
88-NPP								
89-NPP								
90-PHY								
91-PHY								
92-PHY								
93-PHY								
94-PHY								
95-SUP								
97-NPP								
98-PHY								
99-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 8

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

A5 Pharmacy
C0 Sleep Medicine
C1 Centralized Flu
C2 Indirect Payment Procedure
C3 Interventional Cardiology
C4 Restricted Use
C5 General Dentist
C6 Hospitalist
C7 Advanced Heart Failure and Transplant Cardiology
C8 Medical Toxicology
C9 Hematopoietic Cell Transplantation and Cellular Therapy
D1 Restricted Use
D2 Restricted Use
D3 Medical Genetics and Genomics

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
A5-SUP								
C0-PHY								
C1-NPP								
C2-NPP								
C3-PHY								
C4-RES								
C5-PHY								
C6-PHY								
C7-PHY								
C8-PHY								
C9-PHY								
D1-RES								
D2-RES								
D3-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 9

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

Total Physicians - The contractor enters in the appropriate column the total of all specialty codes applicable to physicians.

Total LLPs - The contractor enters in the appropriate column the total of all specialty codes applicable to limited license physicians.

Total NPPs - The contractor enters in the appropriate column the total of all specialty codes applicable to non-physician practitioners.

Total Physicians/LLPs/NPPs - The contractor enters in the appropriate column the sum of all physicians, LLPs and NPPs.

Total Suppliers - The contractor enters in the appropriate column the total of all specialty codes applicable to suppliers.

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
TOTALs								
PHYs*								
LLPs*								
NPPs*								
PHYs/LLPS/NPPs*								
SUPs*								

* These lines do not represent specific specialty codes. They are the totals of the specialty sub-groups.