CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2319	**Date: October 17, 2011**
	Change Request 7573

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 3, 2011 The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Calendar Year (CY) 2012 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. SUMMARY OF CHANGES: This instruction furnishes contractors with the materials needed for the 2012 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, section 30.3.12.

EFFECTIVE DATE: November 3, 2011
NOTE: The effective date is not the date of service for this instruction.
IMPLEMENTATION DATE: November 8, 2011

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
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2319	Date: October 17, 2011	Change Request: 7573

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SUBJECT: Calendar Year (CY) 2012 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

Effective Date: November 3, 2011.
NOTE: The effective date is not the date of service for this instruction.

Implementation Date: November 8, 2011

I. GENERAL INFORMATION

A. Background: Contractors conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision by December 31. Providers (physicians, practitioners, or suppliers) who want to maintain their current PAR status (PAR or non PAR) do not need to take any action in the upcoming annual participation enrollment program. To sign a participating agreement is to agree to accept assignment for all covered services that are provided to Medicare patients. After the enrollment period ends, contractors publish an updated list of participating physicians, practitioners, and suppliers in their local MEDPARDs on their Web sites.

B. Policy: The annual participation enrollment program for CY 2012 will commence on November 14, 2011, and will run through December 31, 2011.

The purpose of this Recurring Update Notification is to furnish contractors with material needed for the CY 2012 participation enrollment effort. The following documents are attached:

- A Participation Announcement; and
- A Blank Participation Agreement.

Contractors shall produce and mail the participation enrollment material on a postcard as directed in Publication 100-04, Chapter 1, section 30.3.12. **Contractors shall place the new fees (physician fee schedule fees and anesthesia conversion factors) on their Web site for providers to access and download. The information contained in this Recurring Update Notification must be kept CONFIDENTIAL until the Physician Fee Schedule Final Rule is put on display. Fees should not be posted on the Web or be mailed until after the final rule is put on display.**

Contractors will no longer receive a Special Edition (SE) Medicare Learning Network (MLN) Matters article. Be sure to post the following language on your Web site:

"We encourage you to visit the Medicare Learning Network (http://www.cms.gov/MLNGenInfo/)--the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and

CD-ROMs) are also available and can be accessed at: http://www.cms.gov/MLNProducts/. You can also find other important physician Web sites by visiting the Physician Center Web page at: http://www.cms.gov/center/physician.asp".

In CR 7412 (Postcard Mailing for the Annual Participation Open Enrollment Period), CMS directed contractors to produce a postcard mailing, instead of a CD. The postcards should be mailed in time for physicians, practitioners, and suppliers to receive the participation enrollment material by November 14, but should not be mailed before November 8.

The CMS plans to release the Medicare Physician Fee Schedule Database (MPFSDB) and the anesthesia conversion factors to contractors electronically in late October. This data must also be kept confidential until the physician fee schedule final rule is put on display. CMS will send all contractors an e-mail notice when the Physician Fee Schedule Final Rule has been put on display.

NOTE: The CMS will advise all contractors the process that shall be used when the MPFS files (anesthesia and purchase diagnosis) are available. Contractors shall download (from the mainframe), test and implement the files. The CMS will update Publication 100-04, Chapter 1, section 30.3.12 in a separate instruction reflecting this information.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7573.1	Contractors shall mail a postcard for the annual open participation enrollment mailing by November 14, 2011, but not before November 8, 2011. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.	X			X						
7573.2	Contractors shall display the fee data prominently on their Web site. For CY 2012 disclosure reports, contractors shall use the following format for displaying fees on the Web and/or hardcopy: • Procedure code (including professional and technical component modifiers, as applicable); • Par amount (non-facility);	X			X						

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	
	• Par amount (facility-based); • Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); and • Limiting charge (facility-based).										
7573.3	Contractors shall provide a link to the 2012 Medicare Fee Schedule on their Web site. **NOTE:** Disclosure materials may not be released on your Web site until you receive notification from CMS that the Physician Fee Schedule Final Rule has been put on display.	X			X						
7573.4	For CY 2012 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.	X			X						
7573.5	Contractors shall display the fee schedule using a provider friendly format from which providers can download their particular locality. Providers should not have to download the whole fee schedule file.	X			X						
7573.6	Contractors shall post the following language on your Web site: "We encourage you to visit the Medicare Learning Network (http://www.cms.gov/MLNGenInfo/)-- the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: http://www.cms.gov/MLNProducts/. You can also find other important physician Web sites by visiting the Physician Center Web page at: http://www.cms.gov/center/physician.asp".	X			X						
7573.7	Effective immediately, contractors shall educate	X			X						

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	
	providers via their Web site and whatever other provider outreach that can be utilized that the fees will be placed on the contractor Web site after the CY 2012 physician fee schedule regulation is put on display.										
7573.8	Contractors shall prominently display the announcement and participation agreement on the Web site.	X			X						
7573.9	Contractors shall insert their Web site address for providers to use to access the CY 2012 payment rates in the space available at the end of the Participation Announcement sheet.	X			X						
7573.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) in the blank lines as indicated at the end of the Participation Announcement sheet.	X			X						
7573.11	Contractors shall inform providers via their listserv when the CY 2012 fees are posted to their Web site**.**	X			X						
7573.12	Contractors shall produce hard copy disclosures for providers who do not have Internet access. **NOTE**: Contractors have the discretion to produce more than 2 percent hardcopy if needed.	X			X						
7573.13	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.	X			X						
7573.13.1	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.	X			X						
7573.14	The MPFSDB will contain the CY 2012 fee schedule amounts. Contractors shall include fee amounts for procedure codes with status indicators of A, T, and R (if Relative Value Units (RVUs) have been established by CMS). The following statements must be included on the fee disclosure reports: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2011 by the American Medical Association." "These amounts apply when service is performed in a	X			X						

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	
	facility setting." (This statement should be made applicable to those services subject to a differential based on place of service.) "The payment for the technical component is capped at the OPPS amount." (This statement should be made applicable to services in which the technical portion was capped at the Outpatient Prospective Payment System amount.) See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.										
7573.15	If contractors choose to use code descriptors on their Web site, they must use the short descriptors contained in the Healthcare Common Procedure Coding System (HCPCS) file and the MPFSDB. If contractors find descriptor discrepancies between these two files, use the HCPCS file short descriptor. **NOTE**: The CMS has signed agreements with the American Medical Association regarding use of CPT, and the American Dental Association regarding use of Current Dental Terminology (CDT), on Medicare contractor Web sites, CD-ROMs, bulletin boards, and other electronic communications (refer to the IOM Publication 100-04, Chapter 23, section 20.7).	X			X						
7573.16	Contractors shall process participation elections and withdraws post-marked before January 1, 2012.	X			X						
7573.17	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2012 without regional office prior authorization and advanced approved funding for this purpose.	X			X						
7573.18	If contractors receive inquiries from a customer who does not have access to the contractor Web site, they shall ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via phone or letter.	X			X						
7573.19	Contractors shall load their local MEDPARD	X			X						

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	
	information for providers on their Web site within 30 days following the close of the annual participation enrollment process.										
7573.20	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.	X			X						
7573.21	Contractors shall also inform hospitals and other organizations (i.e., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on your Web site.	X			X						
7573.22	Contractors shall convert the Form CMS-460 into a document that allows providers to enter all required information (except for the signature and effective date in item 2) before printing. Then, the provider will only have to print out the Form CMS-460, sign it, and mail it to the contractor.	X			X						
7573.23	Contractors shall protect all parts of the Form CMS-460 that do not require data entry from being altered. (The provider can only be allowed to enter their required information, and not change any other parts of the Form CMS-460).	X			X						
7573.24	Contractors shall continue to plug-in the January 1, (appropriate year), effective date in item 2 of the Form CMS-460 included on your Web site.	X			X						
7573.25	For any par changes submitted by providers who do <u>not</u> have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), contractors shall process the par request and send a Revalidation Letter directing the provider to complete the Medicare enrollment application (i.e., paper or Internet-based PECOS) within 60 days.	X			X						
7573.26	Contractors shall refer to the IOM Pub. 100-04, Chapter 1, section 30.3.12.1 for more information about the postcard mailing and Web site.	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	
7573.27	None. An MLN Matters Article related directly to this change request is not needed. Mailing the postcard (except the fees) and posting the entire participation enrollment materials and the MEDPARD information is considered provider education. Contractors shall follow the instructions regarding the dates for releasing/mailing these materials that are contained in this Recurring Update Notification.	X			X						

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): April Billingsley, (410) 786-0140, april.billingsley@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include 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.

2 Attachments: Announcement and Form CMS-460 (4/10)

Announcement
About Medicare Participation for Calendar Year 2012

Medicare Physician Fee Schedule Update:

In 2012, the Centers for Medicare & Medicaid Services (CMS) is implementing payment updates and policy changes to the Medicare Physician Fee Schedule, including:

- Policies and procedures to identify and provide accurate payment for misvalued services; and
- Changes to the factors used to adjust physician fee schedule payment for geographic differences in physicians' practice costs.

Incentives and Payment Adjustments for Quality Reporting:

We are continuing our efforts to promote improvement in quality of care and patient outcomes through the Electronic Prescribing (eRx) Incentive Program and the Physician Quality Reporting System (PQRS).

Eligible professionals or group practices that meet satisfactory reporting requirements under the PQRS in calendar year (CY) 2011 will be eligible for incentive payments equal to 1.0 percent of their total estimated allowed charges for the reporting period. This incentive payment will be made in CY 2012. In addition, eligible professionals or group practices that meet satisfactory reporting requirements under the PQRS in CY 2012 will be eligible for incentive payments equal to 0.5 percent of their total estimated allowed charges for the reporting period.

Eligible professionals or group practices that meet the requirements of the eRx Incentive Program in CY 2011 will be eligible for incentive payments equal to 1.0 of their total estimated allowed charges for the reporting period. Similar to the PQRS, this incentive payment will be made in CY 2012. In addition, eligible professionals or group practices that meet the requirements of the eRx Incentive Program in CY 2012 will be eligible for incentive payments equal to 1.0 percent of their total estimated allowed charges for the reporting period.

Eligible professionals who did not become successful electronic prescribers by reporting on the electronic prescribing measure for at least 10 unique events from January 1, 2011, through June 30, 2011, or were not granted an exemption due to a significant hardship will be subject to a negative payment adjustment equal to 1.0 percent of their fee schedule amounts for covered professional services furnished during 2012. Feedback reports based on information reported by eligible

professionals to CMS during the 2012 eRx payment adjustment reporting period (i.e., January 1, 2011-June 30, 2011) are expected to be made available to eligible professionals in late-2011.

In addition, a negative payment adjustment equal to 1.5 percent of the physician fee schedule amounts for covered professional services furnished during 2013 will apply to eligible professionals unless: (1) the eligible professional was a successful electronic prescriber for purposes of the 2011 eRx incentive; (2) the eligible professional becomes a successful electronic prescriber by reporting on the electronic prescribing measure on at least 10 unique events (which need not be associated with the measure's denominator) from January 1, 2012, through June 30, 2012; or (3) the eligible professional was granted an exemption due to a significant hardship. More information regarding the eRx payment adjustment is available on the CMS eRx Incentive Program website at http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp#TopOfPage.

Medicare and Medicaid EHR Incentive Programs:

Eligible professionals can also receive incentive payments for the use of certified electronic health record (EHR) technology under the Medicare and Medicaid EHR Incentive Programs. Eligible professionals who successfully demonstrate meaningful use of certified EHR technology under the Medicare EHR Incentive Program are eligible to receive up to $44,000 in incentive payments over 5 years. Eligible professionals who do not successfully demonstrate meaningful use of certified EHR technology by 2015 will be subject to payment adjustments. There is a more generous incentive program for Medicaid eligible professionals. Visit the Medicare and Medicaid EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms/.

Pre-Existing Condition Insurance Plan (PCIP):

The Affordable Care Act created the state-based PCIP program, which provides access to affordable healthcare coverage for individuals who have previously had difficulty obtaining health insurance coverage. Each state PCIP offers different benefit designs that cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. PCIP premiums are set in each state based on the prevailing rates. The PCIP program runs until 2014 when there is a universal prohibition on discrimination based on pre-existing conditions, and individuals will have access to affordable health insurance choices through the Exchanges. For more information regarding PCIP programs in each state, including eligibility requirements, premiums, and how to apply, visit: http://www.healthcare.gov/law/provisions/preexisting/index.html.

Seasonal Influenza:

We are encouraging all physicians, practitioners, and suppliers to continue monitoring the Centers for Disease Control and Prevention, CMS, and contractor websites for information about seasonal influenza. Specific provider information as to the latest clinical guidance is available at the following websites: http://www.cdc.gov/h1n1flu/ and www.flu.gov.

Revalidation:

As required in the Affordable Care Act, over the coming months, many providers will receive requests from their respective Medicare claims administration contractors to revalidate their Medicare enrollment. We encourage all practitioners to respond to the request for revalidation by updating and verifying their current provider enrollment information. The easiest way to revalidate your Medicare provider enrollment information is through internet-based PECOS (https://pecos.cms.hhs.gov/pecos/login.do). Providers also may submit and complete an 855 form which can be obtained at (http://www.cms.gov/CMSForms/CMSForms/list.asp). We encourage all practitioners to maintain and update their enrollment records regularly--and to respond timely when requested to do so by their Medicare contractor.

New Payment and Care Delivery Model Tests Underway from the CMS Innovation Center:

The CMS Innovation Center provides a new opportunity to the Medicare, Medicaid, and the Children's Health Insurance Programs to test, evaluate and spread new models of care delivery and payment that can deliver better care and better health at lower cost through continuous improvement. There are many new opportunities for physicians to participate in testing and learning about these new models such as the Bundled Payment for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the Accountable Care Organization Model, the Partnership for Patients patient safety campaign, the Million Hearts campaign, and many others. Please visit the CMS Innovation Center website to learn more: www.innovations.cms.gov.

WHY PARTICIPATE

All physicians, practitioners and suppliers must make their CY 2012 Medicare participation decision by December 31, 2011. Providers who want to maintain their current PAR status (PAR or Non PAR) do not need to take any action during the upcoming annual participation enrollment program. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2012. The majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2011, 96.0 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and you bill for services paid under the Medicare physician fee schedule, your Medicare fee schedule amounts are 5 percent higher. Also, affected providers receive direct and timely reimbursement from Medicare.

WHAT TO DO

If you choose to be a participant in CY 2012:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement enclosed and mail it (or a copy) to each Medicare contractor to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in CY 2012:

- Do nothing if you are currently not participating, or

- If you are currently a participant, write to each Medicare contractor to which you submit claims, advising of your termination effective January 1, 2012. This written notice must be postmarked prior to January 1, 2012.

We hope you will decide to be a Medicare participant in CY 2012. Please call _____ if you have any questions or need further information on participation.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare contractors contacts including the contractor medical directors, please visit the CMS web site at http://www.cms.gov/. For ____(Medicare contractor name)_____, you may contact the following toll-free number(s) for assistance:

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant* _____
_____
_____

National Provider Identifier (NPI)* _____

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare Administrative Contractor (MAC)/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

_____	_____	_____
Signature of participant (or authorized representative of participating organization)	Title (if signer is authorized representative of organization)	Date

(including area code)
Office phone number

*List all names and the NPI under which the participant files claims with the MAC/carrier with whom this agreement is being filed.

CMS-460 (4/10)

Received by
(name of MAC/carrier)

Effective date

Initials of carrier official