CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2567	**Date: October 19, 2012**
	Change Request 8055

This Transmittal is no longer sensitive and is being re-communicated November 6, 2012. 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) 2013 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. SUMMARY OF CHANGES: This instruction furnishes contractors with the information needed for the 2013 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: October 19, 2012
IMPLEMENTATION DATE: November 9, 2012

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	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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

Transmittal: 2567	Date: October 19, 2012	Change Request: 8055

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SUBJECT: Calendar Year (CY) 2013 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: October 19, 2012
IMPLEMENTATION DATE: November 9, 2012

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 2013 will commence on November 15, 2012, and will run through December 31, 2012.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2013 participation enrollment effort. The following documents are attached:

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

Contractors shall mail the participation enrollment 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.**

Contractors will not receive a Special Edition (SE) Medicare Learning Network (MLN) Matters article related to this Change Request (CR), however, be sure to post the following language on your Web site:

"We encourage you to visit the Medicare Learning Network® (MLN) (http://go.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://go.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/Provider-Type/Physician-Center.html?redirect=/center/physician.asp .

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls,

held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html ."

In CR 7412 (Postcard Mailing for the Annual Participation Open Enrollment Period), CMS directed contractors to mail a postcard instead of a CD. The postcards should be mailed in time for physicians, practitioners, and suppliers to receive the participation enrollment material by November 15, but should not be mailed before November 9.

The CMS plans to release the 2013 Medicare Physician Fee Schedule File, including the anesthesia file, 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.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8055.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 15, 2012, but not before November 9, 2012. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X			X						
8055.2	Contractors shall display the fee data prominently on their Web site. For CY 2013 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); • Par amount (facility-based); • Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); • Limiting charge (facility-based); and • *eRx limiting charge. (*NOTE: Contractors shall follow the implementation		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	date of January 7, 2013, regarding the eRx limiting charge information, per CR 7877.)											
8055.3	Contractors shall provide a link to the 2013 Medicare Fee Schedule on their Web site. **NOTE:**Disclosure materials may not be posted on your Web site until you receive notification from CMS that the Physician Fee Schedule Final Rule has been put on display.		X			X						
8055.4	For CY 2013 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X			X						
8055.5	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						
8055.6	Contractors shall post the following language on your Web site: "We encourage you to visit the Medicare Learning Network® (MLN) (http://go.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://go.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/Provider-Type/Physician-Center.html?redirect=/center/physician.asp . In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html ."											
8055.7	Effective immediately, contractors shall educate 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 2013 physician fee schedule regulation is put on display.		X			X						
8055.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X			X						
8055.9	Contractors shall insert their Web site address for providers to use to access the CY 2013 payment rates in the space available at the end of the Participation Announcement sheet.		X			X						
8055.10	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						
8055.11	Contractors shall inform providers via their listserv when the CY 2013 fees are posted to their Web site**.**		X			X						
8055.12	Contractors shall **NOT**produce hard copy disclosures until you receive notification from CMS. **NOTE**: When notified, contractors have the discretion to produce more than 2 percent hardcopy if needed.		X			X						
8055.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X			X						
8055.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8055.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X			X						
8055.13	The MPFSDB will contain the CY 2013 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 2012 by the American Medical Association.” “These amounts apply when service is performed in a 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.) *"Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) Incentive Program." (*NOTE: Contractors shall follow the implementation date of January 7, 2013, regarding the eRx limiting charge information, per CR 7877.) See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.		X			X						
8055.14	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,		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	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).											
8055.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2013.		X			X						
8055.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2013 without regional office prior authorization and advanced approved funding for this purpose.		X			X						
8055.17	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						
8055.18	Contractors shall load their local MEDPARD information for providers on their Web site within 30 days following the close of the annual participation enrollment process.		X			X						
8055.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X			X						
8055.20	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						
8055.21	Contractors shall make sure that the Form CMS-460 is readably available on their web sites in order for their providers to complete needed information and download for their use.		X			X						
8055.21.1	Contractors shall allow 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		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	it to the contractor.											
8055.22	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						
8055.23	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						
8055.24	If possible, contractors shall provide a count of the number of page views that the 2013 Participation Announcement receives from your Web site.		X			X						
8055.24.1	This count shall begin November 15, 2012, through December 31, 2012.		X			X						
8055.24.2	Contractors shall email results of the count to the central office (CO) contact no later than January 31, 2013. The CO contact is: April.Billingsley@cms.hhs.gov		X			X						
8055.25	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						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): April Billingsley, 410-786-0140 or april.billingsley@cms.hhs.gov , Mark Baldwin, 410-786-8139 or Mark.baldwin@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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

Announcement
About Medicare Participation for Calendar Year 2013

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2013 Physician Fee Schedule Final Rule is now available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html. Please review the regulation as there are a number of important changes for calendar year (CY) 2013.

We wish to emphasize the importance and advantages of being a Medicare participating provider, and we are pleased that the favorable trend of participation continued into 2012 with a participate rate of 96.1 percent, the highest ever. As you plan for 2013 and become familiar with the coming changes, we are hopeful that you will continue to be a participating provider or, if you are non-participating, will consider becoming a participating provider.

As a reminder the following incentive programs are available for Medicare physicians in 2013:

- Certain primary care specialties, as authorized by the Affordable Care Act, may receive a 10 percent incentive payment for rendering primary care services;
- Electronic health record incentive payments will continue for eligible professionals who demonstrate meaningful use, and;
- Eligible professionals will continue to have the opportunity to earn incentive payments for participating in the Physician Quality Reporting System.

Please see below for more specific information regarding these programs.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers must make their CY 2013 Medicare participation decision by December 31, 2012. Providers who want to maintain their current participation (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 2013. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. As indicated, during CY 2012, 96.1 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 than if you do not participate.

WHAT TO DO

If you choose to be a participant in CY 2013:

- Do nothing if you are currently participating, or

- If you are not currently a Medicare participant, complete the available blank agreement 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 2013:

- 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, 2013. This written notice must be postmarked prior to January 1, 2013.

We hope you will decide to be a Medicare participant in CY 2013. 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:

In 2013, you will see a continuation of the Medicare program's emphasis on primary care and important incentive and quality of care initiatives. Our goal of better health and better care at lower costs may be seen through a number of programs, some of which are described below.

Primary Care Incentives

In 2013, CMS will continue to make a 10 percent incentive payment for primary care services furnished by primary care practitioners as authorized by the Affordable Care Act. To be eligible for this incentive payment, a physician's Medicare specialty needs to be family medicine, geriatric medicine, pediatric medicine, or internal medicine and primary care services needed to constitute 60 percent of Medicare Part B outpatient services (excluding services provided to hospital inpatients or those in emergency departments) in 2011. Nurse practitioners, clinical nurse specialists, and physician assistants are also eligible for these incentive payments. For the first time in 2013, Medicare payments will explicitly reflect the care required to help a patient transition back to the community following a discharge from a hospital or nursing facility. The new codes will recognize the additional resources required by the physician to coordinate a patient's care following a hospital or nursing facility stay.

Incentives and Payment Adjustments for Quality Reporting

In 2013, eligible professionals (EPs) will have the opportunity to earn incentive payments equal to 0.5 percent of their total allowed Medicare Part B Fee-for-Service charges for services provided during 2013 under both the Physician Quality Reporting System (PQRS) and the Electronic Prescribing (eRx) Incentive Program. Incentive payments earned in 2013 will be paid in CY 2014.

EPs should note that 2013 will also serve as the reporting period for the PQRS payment adjustment that will be applied in 2015. The reporting requirements for the 2015 PQRS payment adjustment are detailed in the 2013 Medicare Physician Fee Schedule (MPFS) Final Rule. Payment adjustments will be applied in CY 2013 and CY 2014 to those EPs who are not successful electronic prescribers under the eRx Incentive Program. EPs can still avoid the 2014 eRx payment adjustment by (1) meeting the reporting requirements for purposes of the 2012 eRx incentive; or (2) reporting the eRx measure on at least 10 unique events from January 1, 2013, through June 30, 2013; or (3) requesting and being granted an exemption due to a significant hardship. CMS expects that EPs will be able to request hardship exemptions via the web in the summer/fall of 2013.

More detailed information is available on the PQRS and eRx Incentive Program websites. We have posted a table on the PQRS website that provides practical summaries of three quality programs—the Value Modifier (VM), PQRS, and the eRx Incentive Program—that affect payments to physicians and other EPs.

PQRS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

eRx Incentive Program website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html

Engaging Physicians in Quality

We believe that physicians are leaders in quality improvement. We continue our efforts to collaborate with physicians and other providers to facilitate quality improvement through quality reporting programs and, beginning this year, the Value Modifier (VM)—a program that links quality to payment by providing for differential payment to physicians based on the quality and cost of care.

CMS recognizes that physician practices vary and measurement must be meaningful to clinical practice. We also know that engaging in quality reporting and improvement requires significant time and resources from physicians and their practices. Thus, maximizing flexibility while minimizing burden from quality programs is critical. This principle is reflected in ongoing improvements to CMS quality programs:

- Physicians can choose how their quality of care will be measured, what measures best reflect their practice and how their payments will be adjusted based on performance.
- Physicians can "report once" for multiple programs, including the Medicare Electronic Health Record (EHR) Incentive Program, PQRS, and the VM.
- Practicing physicians and others contribute new quality measures through open calls for measures and help select measures through the Measures Application Partnership.
- CMS is harmonizing related measures across CMS programs and the private sector to reduce provider reporting burden

Value Modifier (VM) for Services Paid Under the Physician Fee Schedule

CMS is starting to phase-in the VM for certain groups of physicians. The 2013 MPFS Final Rule provides details on the group size criteria of physician groups subject to the VM and the amount of payment adjustments to be applied to physician services starting on January 1, 2015. CY 2013 will be the performance period used for calculating quality and cost measures for the VM.

Groups of physicians meeting the designated size criteria that sign up for and report information under the PQRS in CY 2013 will avoid any negative payment impact in 2015. We are providing those groups that participate under the PQRS the option to elect to have their VM calculated based on performance tiers (high, average, low) of the PQRS measures or CMS calculated administrative claims-based quality measures, and the total per capita cost measures calculated by CMS. Based on the groups' performance, this could mean an upward payment adjustment for high performance and risk of a downward adjustment for poor performance. Groups will need to decide whether to make an election for quality performance tiering to calculate their VM later in 2013. CMS will provide the groups of physicians designated for implementation of the VM with feedback reports in the fall of 2013 that can be used to inform them of their quality and cost performance based on historical data and their options to elect quality tiering under the VM.

Medicare and Medicaid EHR Incentive Programs

CMS recently published criteria for meeting Stage 2 of meaningful use in the Medicare and Medicaid EHR Incentive Programs. Starting in 2014, providers who have met criteria for Stage 1, for a period of two or three years, will need to meet meaningful use criteria for Stage 2. Stage 2 criteria includes new objectives to improve patient care through better clinical decision support, care coordination, and patient engagement. This will help reduce health care costs, save time for doctors and hospitals, and save lives. EPs, hospitals, and critical access hospitals will be required to report on the approved set of clinical quality measures from Stage 2 beginning in 2014.

In order to align programs and reduce the burden on physicians and providers, physicians may simultaneously submit clinical quality measure data for both the Medicare EHR Incentive Program and the

PQRS program electronically; and eligible hospitals and critical access hospitals may do the same through the Inpatient Quality Reporting Program. Beginning in 2014, all physicians and providers beyond the first year of demonstrating meaningful use will be required to report clinical quality measures electronically. For more information about the EHR Incentive Programs and Stage 2, visit www.cms.gov/EHRIncentivePrograms.

Beginning in 2015, those who fail to meet meaningful use for the applicable period may be subject to a payment adjustment to their Medicare claims. To avoid payment adjustments, Medicare EPs must demonstrate meaningful use for the applicable period for each year. EPs may apply for a hardship exception in a number of circumstances. Generally stated these are: if they are a new provider; for unforeseen extreme and uncontrollable circumstances such as a natural disaster; if they face insurmountable barriers to obtaining infrastructure; if they practice in multiple locations and can demonstrate inability to control availability of EHR technology at the majority location(s); or if they can demonstrate difficulty meeting meaningful use because of lack of patient interaction (some specialties are listed in the regulation as having such lack of interaction).

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

The CMS Innovation Center, created by the Affordable Care Act, 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 Comprehensive Primary Care Initiative, the several Accountable Care Organization Models, the Partnership for Patients patient safety campaign, among others. Please visit the CMS Innovation Center website to learn more: www.innovations.cms.gov.

We encourage physicians to join Million Hearts, a U.S. Department of Health and Human Services initiative co-led by the Centers for Disease Control and Prevention and CMS, aimed at preventing 1 million heart attacks and strokes by 2017. Joining this effort means working with your staff and patients to excel in the ABCS: aspirin for those patients at risk, blood pressure control, cholesterol management, and smoking cessation. The initial milestone in Million Hearts is better blood pressure control for the 67 million Americans with hypertension, 36 million of whom are not yet under control. Please visit http://millionhearts.hhs.gov for resources that can be helpful. For questions, contact the Million Hearts team at millionhearts@cms.hhs.gov.

What follows are additional messages and information which we believe will be helpful to you as you plan for 2013.

Revalidation

Over the coming months, many providers will receive requests from their respective Medicare claims administrative contractor to revalidate their Medicare enrollment information. We encourage all practitioners to respond to the request for revalidation by verifying and updating their current provider enrollment information. The easiest way to revalidate your Medicare provider enrollment information is through internet-based Provider Enrollment,
Chain and Ownership System (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 review and update their enrollment records regularly, and respond timely to revalidation requests received by their contractor.

Referral Agent Listserv for DMEPOS Competitive Bidding

The Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program was successfully implemented in nine areas on January 1, 2011 and has preserved beneficiary health status outcomes and access to quality equipment and supplies. Round

2 of the program is targeted to go into effect in 91 metropolitan statistical areas on July 1, 2013. See the locations and the products that will be affected by this second round of competitive bidding at:

Round 2 Locations: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/MSAs_and_CBAs.html

Round 2 Products: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Product_Categories_and_Items.html

CMS will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa. Physicians who refer their patients for durable medical equipment play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the program. In the coming months leading up to the start of Round 2 and the national mail order program of the DMEPOS Competitive Bidding Program, CMS will send out more information that will be helpful for physicians and guide them through the changes that the new program brings. In light of the important role that physicians serve, CMS has adopted the use of a new email update to better communicate the various aspects of the Competitive Bidding Program and to ensure that official information is released and received by physicians as quickly as possible. CMS encourages all physicians to have office staff who help patients with referrals sign up for this new email update to ensure they receive the most accurate and timely information regarding the Competitive Bidding Program. Please sign up for the email updates here: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814

Information Related to the Medicare Prescription Drug (Part D) Coverage

Prescription drug abuse is the Nation's fastest growing drug problem. Additional prescriber awareness and engagement are crucial to addressing this problem. CMS has been working on an approach to help Medicare prescription drug plans identify and manage the most egregious cases of opioid overutilization. If you are contacted by a prescription drug plan about the opioid use of one of your patients, please take the time to provide your feedback and expertise.

Many States have operational Prescription Drug Monitoring Programs (PDMPs). PDMPs are tools used by States to reduce prescription drug abuse and diversion. We encourage you to actively participate in your State's PDMP. For more information about your State's PDMP program and how to obtain access, please visit the following website: http://www.pmpalliance.org/content/pmp-access.

Recently, CMS published a final rule that requires virtually all prescribers, pursuant to certain relationships they have with covered organization health care providers, such as hospitals and group practices, to obtain an individual National Provider Identifier (NPI) and disclose it when needed for a pharmacy claim, if the prescribers have not already done so. Covered organization health care providers must direct prescribers to do so by May 6, 2013. The vast majority of prescribers already have individual NPIs. However, if you are one of the few prescribers who do not, we strongly encourage you to obtain an individual NPI as soon as possible. Obtaining an individual (Type I) NPI and disclosing it on each prescription you write will eliminate the need for follow-up with your office from pharmacies and payers. Obtaining an individual NPI is free of charge and takes approximately twenty (20) minutes. An individual NPI can be obtained on-line at the following link: https://nppes.cms.hhs.gov/NPPES/Welcome.do

We also want you to be aware of changes to Medication Therapy Management (MTM) programs, which may affect your Medicare patients. We encourage each beneficiary to have their MTM action plan and medication list with them when they talk with their doctors and other health care providers. Also, we encourage them to ask their providers to update the documents at every visit. More information about MTM is available at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html.

Finally, physicians can obtain more information about Medicare Part D covered vaccines through a Medical Learning Network publication dedicated to the topic. The article describes which vaccines are covered under Medicare Part B and Medicare Part D. The article can be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0727.pdf.

Seasonal Influenza

We encourage 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/flu/ and www.flu.gov.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this

information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.