CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2818	**Date: November 15, 2013**
	Change Request 8471

Contractors Note: Transmittal 2818, dated November 15, 2013, is no longer sensitive and may be posted to the internet as of December 3, 2013. All other information remains the same.

SUBJECT: Calendar Year (CY) 2014 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: November 15, 2013
IMPLEMENTATION DATE: November 18, 2013

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

Manual Instruction

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

Recurring Update Notification

Pub. 100-04	Transmittal: 2818	Date: November 15, 2013	Change Request: 8471

Contractors Note: Transmittal 2818, dated November 15, 2013, is no longer sensitive and may be posted to the internet as of December 3, 2013. All other information remains the same.

SUBJECT: Calendar Year (CY) 2014 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: November 15, 2013
IMPLEMENTATION DATE: November 18, 2013

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 2014 will commence on November 14, 2013, and will run through December 31, 2013.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2014 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. Fees should not be posted on the Web or be mailed until after the 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 14, but should not be mailed before November 8.

The CMS plans to release the 2014 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

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8471.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 22, 2013, but not before November 8, 2013. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X				X						
8471.2	Contractors shall display the fee data prominently on their Web site. For CY 2014 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);		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	• Non-par amount (facility-based); • Limiting charge (facility-based); and • eRx limiting charge.												
8471.3	Contractors shall provide a link to the 2014 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						
8471.4	For CY 2014 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X				X						
8471.5	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						
8471.6	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 .		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	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 ."												
8471.7	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 2014 physician fee schedule regulation is put on display.		X				X						
8471.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X				X						
8471.9	Contractors shall insert their Web site address for providers to use to access the CY 2014 payment rates in the space available at the end of the Participation Announcement sheet.		X				X						
8471.10	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						
8471.11	Contractors shall inform providers via their listserv when the CY 2014 fees are posted to their Web site**.**		X				X						
8471.12	Contractors shall **NOT** produce hard copy disclosures until you receive notification from CMS. **NOTE**: When notified, contractors have the		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	discretion to produce no more than 2 percent hardcopy if needed.												
8471.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X				X						
8471.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X				X						
8471.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X				X						
8471.13	The MPFSDB will contain the CY 2014 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 2013 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." See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.		X				X						
8471.14	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		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	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).												
8471.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2014.		X				X						
8471.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2014 without regional office prior authorization and advanced approved funding for this purpose.		X				X						
8471.17	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						
8471.18	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						
8471.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X				X						
8471.20	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						
8471.21	Contractors shall make sure that the Form CMS-460 is readily available on their web sites in order for their providers to complete needed information		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	and download for their use.												
8471.21.1	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 it to the contractor.		X				X						
8471.22	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						
8471.23	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						
8471.24	If possible, contractors shall provide a count of the number of page views that the 2014 Participation Announcement receives from your Web site.		X				X						
8471.24.1	This count shall begin November 14, 2013, through December 31, 2013.		X				X						
8471.24.2	Contractors shall email results of the count to the central office (CO) contact no later than January 31, 2014. The CO contact is: April.Billingsley@cms.hhs.gov		X				X						
8471.25	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	FI	CAR	RHH	Other

		A	B	H H H	M A C		R I E R	I	
	None								

IV. SUPPORTING INFORMATION

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

"Should" denotes 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 2014

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 2013 with a participation rate of 96.6 percent, the highest ever. As you plan for 2014 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.

Medicare, in partnership with the provider community, continues to explore and promote ways to improve the quality and efficiency of the health care services its beneficiaries receive. Level part B premiums for 2014 and decreased readmission rates are both early signals of success in this endeavor. We strongly believe that together we can continue the trend of increased quality of care for our beneficiaries. CMS recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings. While Medicare now pays for more preventive benefits without requiring a coinsurance from the beneficiary, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare patients understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

We know that many of you remain concerned about the scheduled reduction to the Medicare Physician Fee Schedule (MPFS) currently expected to take effect on January 1, 2014. The Administration remains strongly opposed to letting this cut take effect. As he has repeatedly made clear, President Obama is committed to a permanent solution to eliminating the Sustainable Growth Rate's cut. We will continue to work with Congress to achieve this goal.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers must make their CY 2014 Medicare participation decision by December 31, 2013. 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 2014. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. As indicated, during CY 2013, 96.6 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 2014:

- 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 2014:

- 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, 2014. This written notice must be postmarked prior to January 1, 2014.

We hope you will decide to be a Medicare participant in CY 2014. Please call _____ if you have any questions or need further information on participation.

The Medicare Learning Network® has developed products in an effort to educate Medicare providers about important Medicare enrollment information and how to use Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll in the Medicare Program and maintain their enrollment information. Please see the list of available products at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf on the CMS website.

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:

The Health Insurance Marketplace – Expanding Health Insurance Coverage:

A primary goal of the Affordable Care Act is to help uninsured and other eligible Americans gain access to quality, affordable health care. Central to this goal is the creation of the Health Insurance Marketplace. Through the Marketplace, eligible Americans will be able to enroll in a health plan to get coverage that starts as soon as January 2014, and no one will be denied coverage on the basis of pre-existing conditions. Beginning in January 2014, expect to see previously uninsured patients newly covered by private health insurance plans and, in many states, expanded Medicaid eligibility. Many of these private plans continue to develop their provider networks.

As a trusted source for health information, your patients may look to you for help navigating the Marketplace. Resources concerning the Marketplace may be found at:

Marketplace.cms.gov: Where organizations and individuals looking to help can get the latest resources and learn more about the Marketplace.

HealthCare.gov: Where individuals can learn about the Marketplace and the upcoming benefits (including where they can find local assistance), or be connected to appropriate resources in states that are running their own Marketplace.

Health Insurance Marketplace Call Center: If you have questions, call 1-800-318-2596. TTY users should call 1-855-889-4325.

At **Marketplace.cms.gov**, there are two articles particularly relevant for clinicians: "10 Things Providers Need to Know" (http://marketplace.cms.gov/getofficialresources/publications-and-articles/10-things-providers-need-to-know.pdf) and "10 Things to Tell Your Patients" (http://marketplace.cms.gov/getofficialresources/publications-and-articles/10-things-to-tell-your-patients.pdf).

Information Related to 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. The Centers for Medicare & Medicaid Services (CMS) has implemented an approach to help Medicare prescription drug plans identify and manage the most egregious cases of opioid overutilization, which often involves multiple prescribers who are not aware of each other. In addition, many opioid analgesics also contain acetaminophen, which is subject to a maximum daily dose of 4 grams as established by the Food and Drug Administration. As you know, higher acetaminophen doses, often involving the use of multiple products, are associated with acute liver failure and may result in liver transplant and death. If you are contacted by a prescription drug plan about the opioid or acetaminophen use of one of your patients, please take the time to provide your feedback and expertise to help assure the safe use of these products.

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

CMS is requesting your help so that prescribers do not override a Medicare beneficiary's choice of pharmacy to fill their Part D prescriptions. CMS is aware that some Part D plans have dispensed prescriptions without confirming that the beneficiary wants to fill that prescription, and if so, if they want the prescription filled by the particular pharmacy that is dispensing it. An example is the plan's/Pharmacy Benefit Managers (PBM's) use of prior authorization forms to re-direct a prescription to the plan's and/or PBM's own pharmacy or to mail order instead of the pharmacy at which the beneficiary presented the original prescription. While CMS is addressing this issue directly with Part D plans, we want Medicare providers to assist in this area.

Please check your data in the National Plan and Provider Enumeration System (NPPES) and confirm that it still correctly describes you as a health care provider. There is increased focus on the NPI as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials, because it may appear to Medicare oversight authorities that you may not be lawfully prescribing Part D drugs. Comprehensive information about how the NPI rule pertains to prescribers may be obtained from the CMS website at: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/Downloads/NPI-Requirements-for-Prescribers.pdf.

Medicare Shared Savings Program:

Currently, over 75,000 physicians participate in Accountable Care Organizations (ACO) in the Medicare Shared Savings Program. When an ACO succeeds in both delivering high-quality care and lowering growth in Medicare spending on patients its providers serve, it will share in the savings it achieves for the Medicare program.

Eligible professionals (i.e. physicians and other practitioners) in an ACO that successfully reports the PQRS group practice reporting option quality measures required under the Shared Savings Program in any year of the program will be deemed eligible for the PQRS bonus and/or avoid the PQRS payment adjustment, regardless of whether the ACO qualifies to share in savings. Groups of physicians that participate in an ACO are also exempt from the application of the value modifier.

We encourage physicians and other practitioners to collaborate with their ACOs so that together they can achieve the goals of the program including successful reporting and performance on quality measures.

We encourage you to consider joining the Medicare Shared Savings Program. Please visit the Medicare Shared Savings Program webpage for more information about the program including how to apply or learn about ACOs in your area - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

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. We encourage you to visit the CMS Innovation Center website to obtain up-to-date opportunities and more information at: 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.

Primary Care Incentives:

In 2014, 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 need to constitute 60 percent of Medicare Part B outpatient services (excluding services provided to hospital inpatients or those in emergency departments) in 2012. Nurse practitioners, clinical nurse specialists, and physician assistants are also eligible for these incentive payments.

In 2014, Medicare will continue to make payments to physicians to coordinate a patient's care during their transition back to the community following a discharge from a hospital or nursing facility. More information on billing for this service is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf. We also answer frequently asked questions on billing for this service: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf.

Also please see the Special Edition MLN Matters Article developed by the Medicare Learning Network®. The article provides a list of questions and answers that respond to the inquiries CMS has received about the Primary Care Incentive Program. The article can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7060.pdf on the CMS website.

Engaging Physicians in Quality:

We believe that physicians are leaders in quality improvement. We continue our efforts to collaborate with physicians and other professionals to facilitate quality improvement through quality reporting programs and, pay for performance programs such as the Value Modifier (VM) program. The VM program links quality to payment by providing for differential payment to physicians based on the quality and cost of care furnished to Medicare patients.

CMS recognizes that physician practices vary and measurement must be meaningful and relevant to clinical practice. We also know that engaging in quality reporting and improvement requires significant time and

resources from physicians and their practices. Thus, developing quality programs that maximize flexibility while minimizing burden is critical. This principle is reflected in ongoing improvements to CMS quality programs, such as:

- Physicians can choose what measures best reflect their practice and how they report measures to CMS.
- Physicians can "report once" for multiple programs, including the Medicare Electronic Health Record (EHR) Incentive Program, PQRS, and the VM.
- Practicing physicians and others can contribute new quality measures through open calls for measures and help select measures through the Measures Application Partnership.
- CMS is aligning related measures across CMS programs and the private sector to reduce provider reporting burden.
- New for the 2014 PQRS program is the option for EPs to participate in Qualified Clinical Data Registries (QCDRs). QCDRs will be able to report, on behalf of EPs, quality measures that meet certain CMS requirements but are not necessarily measures currently in PQRS. Physician specialty societies and boards as well as regional quality improvement collaboratives and others are interested in becoming QCDRs so we encourage you to investigate QCDR options that may be available to you. QCDRs will enable physicians to measure and report on quality metrics that are particularly meaningful to the care they provide.
- You can view the Medicare Learning Network® YouTube video regarding "Implications for the Value-Based Payment" Modifier at: http://www.youtube.com/watch?v=ZxIiW33jkSs

Availability of the 2013 Quality and Resource Use Reports (QRURs):

In the late summer of 2014, we plan to provide QRURs at the Tax Identification Number level to all groups of physicians and to solo practitioners. The QRURs will be based on CY 2013 performance data. These reports will contain performance on the quality and cost measures used to score the quality and cost composites of the Value-Based Payment Modifier and additional information to help physicians coordinate care and improve the quality of care furnished to Medicare beneficiaries. For groups of 100 or more eligible professionals, these QRURs will provide information on how their 2015 payments under the Medicare Physician Fee Schedule will be affected.

Incentives and Payment Adjustments for Quality Reporting:

In 2014, 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 2014 under the Physician Quality Reporting System (PQRS). 2014 is the last year that an incentive is available for PQRS. Incentive payments earned in 2014 will be paid in CY 2015.

The Electronic Prescribing (eRx) Incentive Program, including any payment adjustments for unsuccessful e-prescribing or reporting, will end in 2014. No reporting of electronic prescribing for this program is required in 2014.

EPs should note that 2014 will also serve as the reporting period for the 2016 PQRS payment adjustment. The payment adjustment for 2016 based on 2104 reporting is negative 2.0%. The reporting requirements to avoid the 2016 PQRS payment adjustment are detailed in the CYs 2013 and 2014 Medicare Physician Fee Schedule (MPFS) Final Rule.

Please use the links below to visit the PQRS and eRx Incentive Program websites where more detailed information about these programs are available.

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

You can also find more information by clicking on the Medicare Learning Network® Fact Sheet titled "2013 Physician Quality Reporting System (PQRS): 2015 PQRS Payment Adjustment "located at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2013-PQRS-Updates-ICN908705.pdf on the CMS website and also the Fact Sheet titled 2013 Electronic Prescribing (eRx) Incentive Program: Participation for the Incentive Payment Made Simple located at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2013-eRx-Participation-Incentive-Payment.pdf.

Medicare and Medicaid EHR Incentive Programs:

Stage 2 is just around the corner. 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 include 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. Beginning in 2014, EPs, hospitals, and critical access hospitals will also be required to report on a new set of clinical quality measures, regardless of whether at Stage 1 or Stage 2.

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 able 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 2015 payment adjustments, Medicare EPs must demonstrate meaningful use prior to October 1, 2014. Don't wait until the last minute to meet meaningful use! For more information about payment adjustments, please visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf.

The Medicare Learning Network® also offers a Quick Reference Guide about EHR reporting. You can view the guide at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PQRS-EHR-Incentive-Pilot-Quick-Ref-Guide.pdf on the CMS website.

eHealth:

CMS recently launched the eHealth initiative to help providers deliver high-quality health care by simplifying the use of electronic standards and encouraging the adoption of health information technology. eHealth addresses recent federal electronic health directives that require new paradigms for standardized data-driven operational processes to support three national health care goals: ***improved quality of care***, ***improved health outcomes***, and ***reduced costs without compromising quality***. The eHealth initiative will help to achieve these goals by encouraging interoperability—standardizing and facilitating the sharing of health care data securely and easily among health care providers across different sites of care.

For more information, visit www.cms.gov/eHealth.

Revalidation:

Over the coming months, many providers will receive requests from their respective Medicare Administrative Contractors (MACs) to revalidate their Medicare enrollment information. Providers can revalidate their enrollment information using either Internet-based Provider Enrollment,

Chain and Ownership System found at https://pecos.cms.hhs.gov/pecos/login.do or the CMS 855 paper application found at http://www.cms.gov/CMSForms/CMSForms/list.asp. We encourage all practitioners to respond timely to revalidation requests received by their MAC. Failure to submit a complete revalidation application, including all supporting documents may result in deactivation of your Medicare billing privileges.

See the Medicare Learning Network® MLN Matters Special Edition Article on this subject. It can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf on the CMS website.

The Medicare Learning Network:

The Medicare Learning Network® (MLN) now offers a weekly electronic newsletter, the *MLN Connects Provider eNews.* View past editions at http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html. The clickable table of contents allows you to move directly to items of interest to you, such as upcoming calls and events; and CMS program information, including ICD-10, EHR incentive programs, Medicare enrollment, CMS quality incentive programs and MLN educational materials. To subscribe, go to https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819. All you need is a valid e-mail address.

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