CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3917	**Date: November 8, 2017**
	Change Request 10351

SUBJECT: Calendar Year (CY) 2018 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 2018 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: December 8, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: 30 days following the close of the annual participation enrollment process for BR 10351.18; November 8, 2017 - for all other requirements

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 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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3917	Date: November 8, 2017	Change Request: 10351

SUBJECT: Calendar Year (CY) 2018 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: December 8, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: 30 days following the close of the annual participation enrollment process for BR 10351.18; November 8, 2017 - for all other requirements

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 2018 will commence on November 14, 2017, and will run through December 31, 2017.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2018 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://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html , and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-

Center.html .

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 2018 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	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10351.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2017, but not before November 8, 2017. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X							
10351.2	Contractors shall display the fee data prominently on their Web site. For CY 2018 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);		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Limiting charge (non-facility); • Non-par amount (facility-based); • Limiting charge (facility-based); • EHR (Electronic Health Records) Limiting Charge; • PQRS (Physician Quality Reporting System) Limiting Charge; • EHR + PQRS Limiting Charge									
10351.3	Contractors shall provide a link to the 2018 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							
10351.4	For CY 2018 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X							
10351.5	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							
10351.6	Contractors shall post the following language on your Web site: *"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) 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:*		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html, and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html . *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 ."*									
10351.7	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 2018 physician fee schedule regulation is put on display.		X							
10351.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X							
10351.9	Contractors shall insert their Web site address for providers to use to access the CY 2018 payment rates in the space available at the end of the Participation Announcement sheet.		X							
10351.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) as indicated at the end of the Participation Announcement sheet.		X							
10351.11	Contractors shall inform providers via their listserv		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	when the CY 2018 fees are posted to their Web site**.**									
10351.12	Contractors shall **NOT** produce hard copy disclosures until January 1, 2018 unless otherwise notified by CMS. **NOTE**: Contractors have the discretion to produce no more than 2 percent hardcopy if needed.		X							
10351.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
10351.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
10351.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
10351.13	The Medicare Physician Fee Schedule Database (MPFSDB) will contain the CY 2018 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 2017 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 the EHR Negative adjustment program." "Limiting Charge reduced based on the PQRS Negative adjustment program."		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	"Limiting Charge reduced for Eligible Professionals (EPs) that are subject to both EHR and PQRS Negative adjustment program." See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.									
10351.14	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, 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							
10351.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2018.		X							
10351.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2018 without regional office prior authorization and advanced approved funding for this purpose.		X							
10351.17	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							
10351.18	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							
10351.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
10351.20	Contractors shall also inform hospitals and other		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
10351.21	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 and download for their use.		X							
10351.21.1	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							
10351.22	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							
10351.23	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							
10351.24	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							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Announcement
About Medicare Participation for Calendar Year 2018

CMS's goals include (1) empowering patients and doctors to make decisions about their healthcare, (2) ushering in a new era of flexibility and local leadership (3) improving the CMS customer experience, and (4) supporting innovative approaches to improve quality, access, and affordability. We wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider, and we are pleased that the favorable trend of participation continued into 2017 with a participation rate of 97.5 percent. As you plan for 2018 and become familiar with the coming changes, we hope that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

CMS strives to empower providers and patients to transform the healthcare delivery system through the individual health care decisions made by patients and professionals. Our policies support patient-centered care to improve health outcomes and efficiency. CMS will ensure each beneficiary is empowered to select and access the care that is right for them by protecting the doctor-patient relationship; reducing burden on providers and patients; empowering seniors and increasing satisfaction; advancing innovation; and fighting fraud. CMS will actively engage stakeholders to enhance the dialogue and listen to feedback from those who are caring for patients.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2018 Medicare participation decision by December 31, 2017. Providers who want to maintain their current PAR status or Non-PAR status do not need to take any action during the upcoming annual participation enrollment period. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2018. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2017, 97.5 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and bill for services paid under the Medicare physician fee schedule (MPFS), your Medicare fee schedule amounts are 5 percent higher than if you do not participate. Your Medicare

Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

WHAT TO DO

If you choose to be a PAR physician in CY 2018:

- 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 MAC 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 2018:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each MAC to which you submit claims, advising of the termination of your participation in the participating physician program effective January 1, 2018. This written notice must be postmarked prior to January 1, 2018.

We hope you will decide to be a Medicare participant in CY 2018. Please call [MACs insert phone number] if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) offers many products on how providers and suppliers can enroll in the Medicare Program. These products include specific information for physicians and other Part B suppliers; ordering/referring providers; institutional providers; and Durable Medical Equipment, Prosthetics, Orthotics and Supplies suppliers as well as information on the electronic Medicare enrollment system, Provider Enrollment, Chain and Ownership System (PECOS).

Opt Out of Medicare Enrollment:

Enrollment in Medicare offers a number of benefits to providers, including timely reimbursement for services rendered. However, enrollment in the program does carry a number of requirements. For example, providers must comply with numerous reporting requirements that consume time that they would rather spend with patients. We seek to reform the Medicare program to allow providers more flexibility to meet the needs of patients.

Certain physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. Opting out of Medicare allows the beneficiary and the provider to directly negotiate reimbursement for healthcare services. While Medicare would not reimburse for services provided by an "opt-out" physician, beneficiaries and providers would have the flexibility to set mutually acceptable reimbursement terms through a negotiated private contract. Providers that opt out can offer and enter into arrangements with beneficiaries that would otherwise be prohibited under Medicare. Opted out physicians also need not follow certain Medicare requirements such as deciding on a case by case basis whether, in compliance with Medicare's rules and guidance, to provide an advance beneficiary notice of noncoverage. Medicare will still reimburse providers for services

rendered to beneficiaries with whom they have not privately contracted as a result of a medical emergency. More information can be found by visiting Opt-Out Affidavits.

New Medicare Cards and Numbers:

In April 2018, CMS will start mailing Medicare cards with new Medicare numbers (known as Medicare Beneficiary Identifiers or MBIs) to all Medicare beneficiaries. The MBI will replace the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) for transactions like billing, eligibility status, and claim status after a transition period. Make sure your systems are ready by April 2018:

- Accept the new MBI Format. Ask your billing and office staff if your systems will be ready to accept the 11 digit alphanumeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change. Make and internally test changes to your practice management systems and business processes by April 2018, before we mail the new Medicare cards.
- Verify your Medicare patients' addresses; they will not get a new card if their address is not correct. If the address you have on file is different from the address you receive in electronic eligibility transaction responses from us, encourage your Medicare patients to correct their address in Medicare's records through the Social Security Administration. This may require coordination between your billing and office staff.
- Identify your Medicare patients who qualify for Medicare under the Railroad Retirement Board (RRB). You will no longer be able to distinguish RRB patients by the number on the new Medicare card. You will be able to identify them by the RRB logo on their card, and we will return a message on the eligibility transaction response for an RRB patient. You must identify them differently to send Medicare claims to the RRB Specialty Medicare Administrative Contractor (MAC), Palmetto GBA.
- Update your practice management system's patient numbers to automatically accept the new MBI from the remittance advice (835) transaction. Beginning in October 2018 through the transition period, we will return your patient's MBI on every remittance advice for claims you submit with a valid and active HICN.
- Attend our quarterly calls to get more information. We will let you know when calls are scheduled in MLN Connects.
- Visit our New Medicare Card Overview and Provider webpages for the latest details.

Transitioning from a Patchwork of Reporting Programs:

The Medicare Access and CHIP Reauthorization Act of 2015 implemented the Quality Payment Program, which started on January 1, 2017. Doctors and other clinicians are able to practice as they always have, but may receive higher Medicare payments based on their performance and engagement in key activities.

There are two paths in this program:

- The Merit-based Incentive Payment System (MIPS), which replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and Medicare Electronic Health Records (EHR) Incentive program for Eligible Professionals (EPs) and;
- Advanced Alternative Payment Models (Advanced APMs)

For the first year of MIPS, you are considered eligible to participate if you are a physician, physician assistant, nurse practitioner, clinical nurse specialist, or a certified registered nurse anesthetist who bills more than $30,000 a year in Medicare Part B allowed charges **and** provides care for more than 100 Medicare patients annually. If you are not sure of your eligibility, please visit the Quality Payment Program website and use the MIPS look-up tool.

For the transition year, MIPS offers flexibilities for clinicians that have 100 or fewer patient-facing encounters (referred to as non-patient facing clinicians), clinicians with 75% or more of their Medicare services performed in the inpatient, on campus outpatient department or emergency department (referred to as hospital- based clinicians), clinicians practicing in a MIPS APM (such as the Next Generation Accountable Care Organization (ACO) Model and the Medicare Shared Savings Program) as well as clinicians in small practices, rural areas, and designated Health Professional Shortage Areas (HPSA).

Though the first performance year began January 1st, it is not too late to get started. You can submit data as late as Dec 31st, and still avoid the negative payment adjustment. However, more data increases your likelihood of earning a positive payment adjustment. If you are eligible to participate but choose not to submit data, you will get a **negative 4% payment adjustment**, which will go into effect on January 1, 2019.

Stakeholder feedback is the hallmark of the Quality Payment Program. We use a user-centered approach to ensure that we design a program based on clinician feedback that reduces unnecessary burden, while keeping Medicare beneficiaries as the primary focus. A few highlights of our efforts include the following:

- As of September 2017, CMS has conducted and/or participated in approximately 630 stakeholder training and outreach events including webinars, national provider calls, listening sessions and individual speaking engagements in 2017.
- Measures and activities to be included in the program are proposed by or developed in collaboration with stakeholders. Most recently, CMS made available episode-based cost measure field test reports to groups and solo practitioners to gather feedback on 8 cost measure specifications and report formats before the measures are considered for use in the Quality Payment Program. These 8 measures were developed with input from nearly 150 clinicians affiliated with 100 national specialty societies.

As we move into year 2 of the program, CMS is continuing to gather stakeholder feedback, starting with the release of the Quality Payment Program year 2 proposed rule, in June 2017, in which we solicited and reviewed nearly 1,300 comments.

We are encouraging you to consider your readiness to participate in an APM, a care organization, or approach that let practices earn more for taking on some risk related to their patients' outcomes. You

may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM. To qualify for the 5% incentive payment, you must receive at least 25% of Medicare covered professional services or see at least 20% of your Medicare patients through an Advanced APM in 2017. Examples of Advanced APMs include Medicare Shared Savings Program Track 2 and 3. A full list of Advanced APMs is available here.

Technical assistance and support is available to help you navigate the program. To get started, visit the QPP website, email us at qpp@cms.hhs.gov or call 1-866-288-8292 weekdays from 8 AM to 8 PM Eastern Time.

Availability of the 2016 Annual and Supplemental Quality and Resource Use Reports (QRURs):

We encourage all groups and solo practitioners nationwide to access their 2016 Annual QRURs, which were made available in September 2017. The 2016 Annual QRURs show how groups and solo practices performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier and indicate if physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists will receive an upward, neutral or downward Value Modifier adjustment to their payments for items and services rendered under the Medicare Physician Fee Schedule in 2018. Detailed information about the 2016 Annual QRURs is available on the 2016 QRUR and 2018 Value Modifier website.

Please note that the amount of the Value Modifier payment adjustment shown in the 2016 Annual QRURs is based on proposals that were included in the 2018 Medicare Physician Fee Schedule (PFS) Proposed Rule and is subject to change. The 2018 Value Modifier proposals included reducing by half the automatic downward payment adjustment for practices that did not meet the minimum quality reporting requirements; holding all practices that met the minimum quality reporting requirements harmless from downward payment adjustments based on performance; and reducing the maximum upward payment adjustment for performance for large practices to align with the adjustment for small and solo practices.

The Annual QRURs are available on the CMS Enterprise Portal and can be accessed by an authorized representative of the practice using an Enterprise Identity Management (EIDM) account with the correct role. Please see the How to Obtain a QRUR website for instructions on how to set up an EIDM account and access your practice's QRUR. There is a new feature available on the CMS Enterprise Portal that will allow a representative of a practice to look up the practice's current and prior years' Value Modifier and Physician Quality Reporting System (PQRS) payment adjustments, and find out which feedback reports are available for the practice (i.e., the Annual QRUR, PQRS Feedback Report, Mid-year QRUR, and Supplemental QRUR). Please note that an EIDM account is not needed to use this feature. Instructions for using this feature are available in the Guide for Accessing the Payment Adjustment and Reports Lookup Feature.

For more information on CMS Quality Programs:

PQRS

Medicare EHR Incentive Program

Value-Based Programs

Long-Term Care Hospital Quality Reporting Program

Skilled Nursing Facility Quality Reporting Program

Inpatient Rehabilitation Facility Quality Reporting Program

Hospice Quality Reporting Program

Home Health Quality Reporting Program

National Plan and Provider Enumeration System (NPPES) Taxonomy:

Please check your data in NPPES and confirm that it still correctly reflects you as a health care provider. There is increased focus on the National Provider Identifier (NPI) as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials, as 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 here.

Prescription Drug Abuse:

Prescription drug abuse is the nation's fastest growing drug problem. Additional prescriber awareness and engagement are crucial to addressing this problem. 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 and pharmacies who are not aware of each other. 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 to help assure the safe use of these products.

Prescriber Identifiers in Research:

You should be aware that CMS now allows researchers to request the release of unencrypted prescriber identifiers contained in Medicare Part D data. This change in policy now gives researchers the ability to conduct important research that involves identified prescribers, which will increase the positive contributions researchers make to the evaluation and function of the Part D program. This access supports CMS's growing role as a value-based purchaser of health care, and is only granted pursuant to CMS's policies and procedures for release of such data to researchers.

Simplifying Identification of Qualified Medicare Beneficiaries (QMBs):

Many Medicare beneficiaries with limited incomes and resources are also covered by their state's QMB program. This means that the state Medicaid agency is responsible for these beneficiaries' Medicare cost sharing. We encourage all Medicare physicians and other practitioners to serve individuals eligible for the QMB program.

We also remind all Medicare physicians and other practitioners that they may not bill their QMB patients for Medicare cost sharing, including deductibles, coinsurance, and copayments. These rules apply to all QMB patients, including those enrolled in a Medicare Advantage (Part C) plan. Under federal law, Medicare payment plus any Medicaid payment are considered payment in full for services rendered to a beneficiary participating in the QMB program.

CMS is implementing several systems changes to simplify providers' ability to identify which of their patients have QMB status. As of October 2, 2017, each Medicare Remittance Advice for all Parts A and B original Medicare claims now inform providers of the beneficiary's QMB status and will also indicate $0 cost-sharing liability. Also starting October 2, 2017, the Medicare Summary Notices sent to Medicare beneficiaries identify whether they are enrolled in the QMB program and protected from being billed for cost sharing. Beginning November 4, 2017, Medicare providers and their authorized billing agents (including third party vendors) can use eligibility data from CMS's HIPPA Eligibility Transaction System (HETS) to identify beneficiaries' QMB enrollment status. HETS will also indicate that QMBs are not responsible for Medicare deductibles, coinsurance, or copays.

We encourage all providers take advantage of these system changes to identify QMB status prior to billing patients for items and services. We also recommend that providers refresh their understanding of how their state handles QMB cost sharing claims. In most states, claims submitted to Medicare are crossed over automatically to the state Medicaid agency. States may require providers to register with their State payment system in order to receive cost sharing payments. Additional information can be found on the QMB Program webpage and in a recently updated MLN Matters memo.

Revalidation:

CMS has mailed revalidation letters to all 1.6 million providers and suppliers by the March 23, 2015 deadline. CMS is resuming regular revalidation cycles every 3 years for Durable Medical Equipment (DME) suppliers and every 5 years for all other providers and suppliers.

CMS has implemented several revalidation processing improvements to include establishing due dates by which a provider or supplier must revalidate. Revalidation due dates will fall on the last day of the month (i.e.: June 30, 2018, July 31, 2018, August 30, 2018) and are posted to the Medicare Revalidation List. Providers and suppliers are expected to submit their revalidation application by this date. Generally, this due date will remain with you throughout subsequent revalidation cycles.

In addition to the posted lists, providers and suppliers will still receive email or mailed revalidation notices from their MACs when they are due to revalidate. Providers can revalidate their enrollment information using the Internet-based PECOS or the CMS-855 paper application. CMS encourages 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.

For more information on the revalidation process, please refer to the Revalidations website and this MLN Matters Special Edition Article.

The Medicare Learning Network® (MLN):

The MLN offers free educational materials for health care professionals on CMS programs, policies, and initiatives. Visit the MLN homepage for information. Subscribe to our MLN Connects® weekly email newsletter for health care professionals to get information on CMS program and policy news; announcements; upcoming events and training; claim, pricer, and code information; and MLN publication updates.

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*

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

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 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)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC/carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

Contact your MAC/carrier to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier 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:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your MAC/carrier.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your MAC/carrier.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC/carrier.

We hope you will decide to be a Medicare participant.

Please call the MAC/carrier in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC/CARRIER. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare Administrative Contractor (MAC)/carrier contacts including the MAC/carrier medical directors, please visit the CMS web site at *http://www.cms.gov/*.