

## Provider Partnership Program (PPP) E-mail Notification Archives

**February 2, 2006**

***I apologize for the short notice but I just received this information regarding a 1:15 p.m. conference call today with Dr. Mark McClellan to discuss the progress of the Medicare Prescription Drug Benefit. Here are the details...***

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Yesterday, HHS Secretary Mike Leavitt released a one-month progress report on the Medicare Prescription Drug Benefit that takes a hard look at what is working and what needs to improve.

HHS announced that Medicare will notify plans that the 30-day transitional coverage period will continue for 60 additional days. This will provide more time for beneficiaries to find out if they can save money by using other drugs that work in a very similar way and may cost significantly less. This action reinforces steps already taken by many prescription drug plans to help assure a smooth transition for beneficiaries.

Today Dr. McClellan will host a call to discuss this update along with other steps that CMS is taking to improve the new Medicare prescription drug benefit. Please join Dr. McClellan today at 1:15pm. Information about this call is below.

**When:** Thursday, February 2, 2006

**Time:** 1:15pm (Due to expected large call volume, the line will be open starting at 1pm)

**Dial-in number:** 1-888-790-7160

**Participant pin code:** 1980163

A copy of the report is available at: <http://www.hhs.gov/secretaryspage.html>

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***Take care ~ Valerie***

*Valerie A. Hart, Director  
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February 2, 2006

As announced on the recent SNF/LTC Open Door Forum, the January 2006 updates to the RAI User's Manual MDS Version 2.0 are now available at:

[http://www.cms.hhs.gov/nursinghomequalityinits/20\\_nhqimds20.asp](http://www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp).

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February 3, 2006

The next in our series of **Medlearn Matters** articles on Medicare prescription drug coverage is now available. "*Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the Medlearn Matters Series on the New Prescription Drug Plans*" (SE0603) contains helpful information and resources for support on questions and issues with Medicare prescription drug coverage. Go to the article directly at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0603.pdf> on the CMS web. In addition, as always, you can visit [Medicare Prescription Drug Coverage Information for Providers](#) for the latest news and other drug coverage resources for Medicare providers.

**Mary K. Loane for**  
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February 7, 2006

**UPDATE: The Centers for Medicare & Medicaid Services (CMS) today announced the target date for responding to the initial mailing of the Medicare Contractor Provider Satisfaction Survey (MCPSS) just passed on January 25, 2006. CMS will contact non-respondents by telephone in the coming weeks to encourage their participation.**

Designed to garner quantifiable data on provider satisfaction with the performance of Medicare Fee-for-Service (FFS) contractors, the survey is being mailed in waves through February to selected provider participants. The target date to respond for each wave of mailings is approximately three weeks after distribution. Many Medicare providers are taking the opportunity to voice their opinions on the administration of the Medicare program. The views of every provider asked to participate are important to the success of this study, as each one represents many other organizations that are similar in size, practice type and geographical location. The feedback from providers will be used to improve the program's efficiency.

Survey administration will continue through April and results will be available to contractors and the public in July 2006. CMS will provide a composite score on the seven key areas of the provider-contractor interface to each contractor as well as an aggregate score to the public. The seven areas include:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

A Federal Register Notice was published on February 3, 2006 to solicit feedback from the public on the 2007 administration of the MCPSS. To be assured consideration, comments and recommendations must be received at the address below, no later than 5 p.m. on April 4, 2006:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C,  
Attention: Bonnie L. Harkless, Room C4–26–05,  
7500 Security Boulevard, Baltimore,  
Maryland 21244–1850.

Further information about the MCPSS is available at: <http://www.cms.hhs.gov/MCPSS/>.

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February 10, 2006

*Happy Friday, everyone! As we on the East Coast prepare for the Nor'easter heading our way, I thought what better time to send you the latest from CMS. This note includes information on:*

- *Medicare Prescription Drug Coverage*
- *Open Door Forums*
- *National Provider Identifier*
- *Ambulance Fee Schedule*
- *Medicare Contractor Provider Satisfaction Survey*

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**MEDICARE OFFERS TIPS WHEN ENROLLING  
IN PRESCRIPTION DRUG PLANS  
People with Medicare Reminded to Enroll Early in the Month**

Millions of people with Medicare enrolled in prescription drug plans are leaving pharmacy counters with their prescription drugs, and at a significant savings since the drug coverage began on Jan. 1.

CMS has posted a tipsheet for Medicare partners about enrolling early in the month at <http://www.cms.hhs.gov/partnerships/downloads/earlyinmonthtipsheet.pdf>.

Attached, please find the CMS press release issued for more information,



final enrollment tips (2).pdf ...



final enrollment tips (2).doc ...

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**Here are a few websites that you might find helpful regarding Medicare Prescription Coverage:**

This one is especially good for Part D information.  
[http://www.cms.hhs.gov/MedlearnProducts/23\\_DrugCoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp)

This one is good for a variety of information, including Parts B/D issues and appeals and exclusion contacts.  
[http://www.cms.hhs.gov/prescriptiondrugcovgenin/04\\_formulary.asp](http://www.cms.hhs.gov/prescriptiondrugcovgenin/04_formulary.asp)

This one is good for appeals and exceptions questions.  
<http://www.medicare.gov/Publications/Pubs/pdf/11112.pdf>

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This notice is to alert you to changes in the frequencies of the **Open Door Forums** schedule.

The currently scheduled monthly Open Door Forums will be held every six weeks. This is effective immediately starting with the February 9, 2006 Hospital/Hospital Quality forum.

The monthly forums include:

- \* Home Health Hospice and DME
- \* Hospital/Hospital Quality
- \* Physician, Nurses, and Allied Health Professionals
- \* Skilled Nursing Facilities/Long Term Care
- \* Rural Health

CMS appreciates the success of the forums as an important channel for communicating with the physician and provider community and will implement a number of strategies to minimize any disruption to providers. We will also continue to explore other technologies to find other means to enhance the quality of the forums. Also, there are a number of new legislative initiatives new legislation the agency is working to implement (after the President signs) and add that CMS will continue to add forums when needed as evidenced by the new Beneficiary Ombudsman forum.

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**NPI News: CMS released several documents on the Electronic File Interchange (EFI) process this week. EFI, also referred to as "bulk enumeration," is a process by which a health care provider or group of providers can have a particular organization (the "EFIO") apply for National Provider Identifiers (NPI) on their behalf. EFI documents posted to the web include a summary, user's guide and technical companion manual.**

**A new Fact Sheet for health care providers who are individuals is also now available.**

Visit <http://www.cms.hhs.gov/NationalProvIdentStand/> to download these new items.

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### **Ambulance Fee Schedule**

Section 1834(1)(3)(B) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2006 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the Ambulance Inflation Factor (AIF). The AIF for calendar year 2006 is 2.5 percent.

The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) also established that for ambulance services furnished during the period July 1, 2004 through December 31, 2009, the ground ambulance base rate is subject to a floor amount, which is determined by establishing nine fee schedules based on each of the nine census divisions, and using the same methodology as was used to establish the national fee schedule. If the regional fee schedule methodology for a given census division results in an amount that is lower than the national ground base rate, then it is not used, and the national fee schedule amount applies for all providers and suppliers in the census division. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the fee schedule portion of the base rate for that census division is equal to a blend of the national rate and the regional rate. For CY 2006, this blend would be 40 percent regional ground base rate and 60 percent national ground base rate. Prior to January 1, 2006, during the transition period, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional (if it applied)) and to the reasonable cost or charge portion of the blended payment amount separately, respectively, for each ambulance provider or supplier. Then, these two amounts were added together to determine the total payment amount for each provider or supplier. As of January 1, 2006, the total payment amount for air ambulance providers and suppliers will be based on 100 percent of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national ambulance fee schedule or 60 percent of the national ambulance fee schedule and 40 percent of the regional ambulance fee schedule.

For more information, go to [http://www.cms.hhs.gov/AmbulanceFeeSchedule/02\\_afspuf.asp](http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp) on the CMS Website.

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**UPDATE: The Centers for Medicare & Medicaid Services (CMS) announced that although the January 25, 2006, target date for responding to the initial mailing of**

**the Medicare Contractor Provider Satisfaction Survey (MCPSS) has passed, CMS will contact non-respondents by telephone in the coming weeks to encourage their participation.**

Designed to garner quantifiable data on provider satisfaction with the performance of Medicare Fee-for-Service (FFS) contractors, the MCPSS survey is being mailed in waves through February to selected provider participants. The target date to respond for each wave of mailings is approximately three weeks after distribution. Many Medicare providers are taking the opportunity to voice their opinions on the administration of the Medicare program. The views of every provider asked to participate are important to the success of this study, as each one represents many other organizations that are similar in size, practice type and geographical location. The feedback from providers will be used to improve the program's efficiency.

Survey administration will continue through April and results will be available to contractors and the public in July 2006. CMS will provide a composite score on the seven key areas of the provider-contractor interface to each contractor as well as an aggregate score to the public. The seven areas include:

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A Federal Register Notice was published on February 3, 2006 to solicit feedback from the public on the 2007 administration of the MCPSS. To be assured consideration, comments and recommendations must be received at the address below, no later than 5 p.m. on April 4, 2006:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C,  
Attention: Bonnie L. Harkless, Room C4-26-05,  
7500 Security Boulevard, Baltimore,  
Maryland 21244-1850.

Further information about the MCPSS is available at: <http://www.cms.hhs.gov/MCPSS/>.

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*I hope you have a great weekend ~ Valerie*

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## February 14, 2005

*February is National Heart Month and CMS wants to take this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests. These tests are used for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke, and include:*

- *Total Cholesterol Test*
- *Cholesterol Test for High-density Lipoproteins*
- *Triglycerides Test*

*This benefit presents a new opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease. CMS needs your help to get the word out about the cardiovascular screening blood tests. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.*

*To assist you in this effort, CMS has developed a variety of educational resources about the many preventive services and screenings covered by Medicare. Products include:*

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals ~ (available in print or as a download)*
- *Quick Reference Information: Medicare Preventive Services ~ two-sided quick reference chart to Medicare preventive services and screenings (available in print or as a download)*
- *Brochures ~ Expanded Benefits, Bone Mass Measurements, Cancer Screenings, Glaucoma Screening, and Adult Immunizations (available in print or as a download)*
- *Medicare Preventive Services Resources CD ROM ~ contains "The Guide", Quick Reference chart, and five brochures listed above*
- *Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services (available as a download only)*
- *Medicare Preventive Services Series Web-based Training Courses*
- *Flu Billing Made Easy Video*

*These products are available, free of charge, from the Medicare Learning Network Medlearn Products web page located at [www.cms.hhs.gov/medlearnProducts](http://www.cms.hhs.gov/medlearnProducts) on the*

*CMS website and may be reprinted or redistributed as needed. Print copies of products may be ordered by clicking on the link to the **Medlearn Products Ordering Page** at the link above.*

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***Happy Valentines Day, everyone!***

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The Centers for Medicare & Medicaid Services (CMS) recently released the attached information for providers and health care professionals regarding Medicare prescription drug coverage. For those of you dealing with issues related to this coverage as it pertains to Part B vs. Part D, we hope you find the information particularly helpful.

The attached materials include:

- Provider / Health Care Professionals Cover Letter
- Medicare Drug Coverage Under Part A, Part B and Part D tip sheet with attached Part B-Part D Guidance Chart
- Part D Drugs /Part D Excluded Drugs Chart



Part BD Charts  
Cover final (2)...



PartsBDFeb6finaldr  
aftV6.doc (7...



Part D drugs- Part  
D Excluded ...

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February 16, 2006

Hello everyone! CMS is in dire need of physician volunteers to pilot test our newest web-based training course ~ **Adult Immunizations**. Physicians are specifically needed in order to award continuing education credits to this course. If you are interested, please fill out the attached form and e-mail it back to CMS [medlearn@cms.hhs.gov](mailto:medlearn@cms.hhs.gov) with a subject line of 'pilot tester'.

Your help is greatly appreciated! Thanks and best regards ~ Valerie



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***Hello everyone ~ I'm sending your Friday reading materials a little earlier this week! Included in this note is information on:***

- \* A CMS Fact Sheet Regarding the Deficity Reducation Act of 2005 (DRA)
- \* NPI Information for Medicare Organization Provider Subparts
- \* Medicare Remit Easy Print Software
- \* Medicare Contractor Provider Satisfaction Survey
- \* A New Fistula First Brochure
- \* Outpatient Therapy Caps: Exceptions Process Required By the DRA

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On Friday, the Centers for Medicare & Medicaid Services (CMS) released a ***fact sheet outlining the Agency's plans to implement provisions included in the Deficit Reduction Act of 2005 (DRA)*** signed by the President on February 8th, that have January 1, 2006 effective dates. The fact sheet provides a general overview of the provisions immediately affected in the DRA and describes what the Medicare program will do to implement these changes retroactively.

The fact sheet is attached and can also be accessed on the CMS website at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1779>.



FS10.2DRA.02.10.  
06.pdf (45 KB)...

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The *National Provider Identifier (NPI)* Final Rule requires health care providers who are organizations and who are covered entities under HIPAA to determine if they have "subparts" that should be assigned NPIs. The NPI Final Rule provides guidance to those health care providers in making those determinations.

The Centers for Medicare & Medicaid Services (CMS) has communicated to the Provider Enrollment staff at the carriers and fiscal intermediaries the Medicare program's expectations concerning the determination of subparts for NPI assignment purposes. CMS has posted a document describing the subpart concept and its relationship to the way in which Medicare enrolls its organization providers at [http://www.cms.hhs.gov/NationalProvIdentStand/06\\_implementation.asp#TopOfPage](http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp#TopOfPage).

This document will be helpful to providers in understanding the issue of subparts and how subpart determination could be done in a way that helps to promote smoother and more efficient Medicare claims processing during the implementation of the NPI in the Medicare program.

The health care industry in general has expressed an interest in being informed of this type of information. CMS is making this information available on the CMS website so that it is easily available to interested parties.

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*Medicare Remit Easy Print (MREP)* software is available from your Medicare carrier or DMERC's website! In an effort to advance toward an electronic environment, the Centers for Medicare & Medicaid Services (CMS) has developed software called *Medicare Remit Easy Print* that enables physicians and suppliers\* to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computer. Remittance advices printed from the **MREP** software mirror the current Standard Paper Remittance Advice (SPR) format. Before using the **MREP** software, physicians and suppliers must have access to HIPAA 835 files.

This software offers new, important capabilities that allow physicians and suppliers to:

- View, search, and print remittance information
- Print and export reports of Denied, Adjusted and Deductible Service Lines

Physicians and suppliers can save time and money with **MREP**! Additional benefits for physicians and suppliers include the ability to:

- Print remittance information for individual or multiple selected claims, which allows physicians/suppliers to forward only those claims that are needed by other

payers for secondary/tertiary payment. This eliminates the need for physicians and suppliers darkening individually identifiable data on the SPR, as they may do today, that does not pertain to the claim for which they are requesting payment.

Find a claim based on customized search criteria, including health insurance claim number, procedure code, rendering provider number.

Receive updates to Claim Adjustment Reason Codes and Remittance Advice Remark Codes three times a year. Physicians and suppliers can sign up on their Carrier or DMERC website to be notified of these updates.

Eliminates physical filing and storage space needs.

**MREP** software information (including how to obtain a free copy) is available on Medicare contractor websites. To learn more about the new **MREP** software and how to receive the HIPAA 835, physicians and suppliers should contact their Medicare carrier or DMERC. Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/> on the CMS website.

Check out **MREP** software! For your reference, a Special Edition Medlearn Matters article (SE0611) is available at: <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0611.pdf> .

\* This includes physicians, providers, suppliers, and qualified non-physician practitioners that bill Medicare Carriers, including DMERCs.

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## **CMS Announces Completion of the First Phase of Medicare Contractor Provider Satisfaction Survey**

**UPDATE: The Centers for Medicare & Medicaid Services (CMS) today announced the target date for responding to the initial mailing of the Medicare Contractor Provider Satisfaction Survey (MCPSS) just passed on January 25, 2006. CMS will contact non-respondents by telephone in the coming weeks to encourage their participation.**

Designed to garner quantifiable data on provider satisfaction with the performance of Medicare Fee-for-Service (FFS) contractors, the survey is being mailed in waves through February 2006 to selected provider participants. The target date to respond for each wave of mailings is approximately three weeks after receipt. Many Medicare providers are taking the opportunity to voice their opinions on the administration of the Medicare program. The views of every provider asked to participate are important to the success of this study, as each one represents many other organizations that are similar in size, practice type and geographical location. The feedback from providers will be used to improve the program's efficiency.

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Attention: Bonnie L. Harkless, Room C4-26-05,  
7500 Security Boulevard, Baltimore,  
Maryland 21244-1850.

Further information about the MCPSS is available at: <http://www.cms.hhs.gov/MCPSS/>.

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The *Fistula First Breakthrough Initiative brochure* is now available in downloadable format on the Medlearn Products web page located at <http://www.cms.hhs.gov/MedlearnProducts> on the CMS website. The brochure provides information about the Fistula First Breakthrough Initiative, the “Creating AV Fistulas in All Eligible Hemodialysis Patients” training module, suggestions for physicians, a chronic kidney disease action plan, clinical practice guidelines, and kidney disease resources.

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***Outpatient Therapy Caps: Exceptions Process Required By the DRA***

**Background:** Section 4541 of the Balanced Budget Act of 1997 (BBA) required the Centers for Medicare & Medicaid Services (CMS) to impose financial limitations or caps on outpatient physical, speech-language and occupational therapy services by all providers, other than hospital outpatient departments. The law required a combined cap for physical therapy and speech-language pathology, and a separate cap for occupational therapy. Due to a series of moratoria enacted subsequently to the BBA, the caps were

only in effect in 1999 and for a few months in 2003. With the expiration of the most recent moratorium, the caps were reinstated on January 1, 2006 at \$1,740 for each cap.

The President signed the Deficit Reduction Act of 2005 (DRA) into law on February 8, 2006. The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006. The law mandates that if CMS does not make a decision within 10 days, the services will be deemed to be medically necessary. This fact sheet describes the exceptions process which will be implemented by our claims processing contractors. Until contractors are able to implement the exceptions process, they are required to accept requests for adjustment of claims for services in 2006 that were denied for exceeding the caps.

**Exceptions Process:** CMS has established an exceptions process that is effective retroactively to January 1, 2006. Providers, whose claims have already been denied because of the caps, should contact their carrier to request that the claim be reopened and reviewed to determine if the beneficiary would have qualified for the exception. In addition, providers who have not yet submitted claims for services on or after January 1, 2006 that qualify for the exception, should submit these claims for payment, and refund to the beneficiary any private payments collected because of the cap.

For more information about the Exceptions Process, view the entire Fact Sheet at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1782> .

A Medlearn Matters article will follow.

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*With best regards ~ Valerie*

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February 17, 2006

**The CMS Publications Mailing List has undergone a major redesign to make our website more user friendly. The web address will remain the same. However, there will be a new process that every user will have to do initially to gain access to the website. The instructions are as follows:**

Go to <http://pubordering.cms.hhs.gov/maillinglist>  
Scroll down beneath the "User Id" and "Password" boxes where you will see two links. One link is for new users and the other states: Registered in our old system? **Link to your account here.**

**Follow the instructions on the screen that appears and select continue. The next screen will ask you to choose a secret question and to type in an answer. Select save and you will be sent to the log on screen where you can log on with the new user id and password.**

**We hope our new design will meet your needs placing orders on our system. As always, you may direct questions to Mailpubs@cms.hhs.gov.**

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### February 23, 2006

On February 21, 2006, CMS issued a National Coverage Determination (NCD) on bariatric surgery for treatment of co-morbid conditions associated with morbid obesity. The decision states that the covered procedures may be performed only in facilities that are (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) (program standards and requirements in effect on February 15, 2006). A full copy of the decision memorandum is available online at [www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=160](http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=160).

By statute, the NCD becomes effective when the NCD is posted on the CMS website. Medicare only reimburses for covered items and services when Medicare rules are met. After February 21, 2006, facilities not certified by ACS or ASBS, contemplating bariatric surgery on Medicare beneficiaries, should have processes in place to ensure that Medicare beneficiaries are aware of their rights and responsibilities. This should include consideration of an Advanced Beneficiary Notice.

We expect to provide claims payment instructions to Medicare contractors on April 1, 2006. A MedLearn Matters article for providers will also be forthcoming shortly.

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FAX: (410) 786-0330

As you know, official CMS information on NPI enumeration and Medicare's implementation plan can be found at [http://www.cms.hhs.gov/NationalProvIdentStand/01\\_overview.asp](http://www.cms.hhs.gov/NationalProvIdentStand/01_overview.asp).

CMS has been asked to share the following information from the **Workgroup for Electronic Data Interchange (WEDI)**, a private sector consortium of leaders in the healthcare community that works to identify practical strategies for reducing administrative costs in healthcare through the implementation of EDI. WEDI's membership includes providers, health plans, consumers, vendors, and standards groups.

In August 2005, WEDI launched the National Provider Identifier Outreach Initiative (NPIOI) program. All program information can be found at <http://www.wedi.org/npioi/>.

WEDI NPIOI workgroup is requesting that provider organizations contact them as soon as possible to become part of the NPIOI information network. As a part of this network, WEDI will be asking that provider organizations disseminate information (e.g. upcoming audiocasts, conferences, other events and new educational products) to their membership as well as to any regional and state-wide healthcare listservs to which they have access.

The NPIOI effort is designed to promote information sharing across the healthcare industry and provide valuable information related to the planning, transition, and implementation of the NPI. The WEDI NPIOI national coordinated strategy will focus on the following:

- increase awareness across all affected providers and organizations;
- provide a consistent level of understanding regarding the regulations; and
- promote the sharing of information regarding NPI planning, transition and implementation experiences, approaches and timelines.

In order to best benefit from March information and to partner with WEDI NPIOI please contact Ann Marie Railing at WEDI as soon as possible, **preferably by March 3, 2006.**

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*With best regards,*

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February 24, 2006

*Happy Friday, everyone! Quite a range of topics in this note, including:*

- \* *Medicare Remit Easy Print Software*
- \* *Hospital Outpatient Coding*
- \* *Home Health ABNs*
- \* *DRA-Related Medlearn Matters Articles*

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**Medicare Remit Easy Print (MREP)** software is available from your Medicare carrier or DMERC's website! In an effort to advance toward an electronic environment, the Centers for Medicare & Medicaid Services (CMS) has developed software called Medicare Remit Easy Print that enables physicians and suppliers\* to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computer. Remittance advices printed from the MREP software mirror the current Standard Paper Remittance Advice (SPR) format. Before using the MREP software, physicians and suppliers must have access to HIPAA 835 files.

This software offers new, important capabilities that allow physicians and suppliers to:

- View, search, and print remittance information
- Print and export reports of Denied, Adjusted and Deductible Service Lines

Physicians and suppliers can save time and money with MREP! Additional benefits for physicians and suppliers include the ability to:

- Print remittance information for individual or multiple selected claims, which allows physicians/suppliers to forward only those claims that are needed by other payers for secondary/tertiary payment. This eliminates the need for physicians and suppliers darkening individually identifiable data on the SPR, as they may do today, that does not pertain to the claim for which they are requesting payment.
- Find a claim based on customized search criteria, including health insurance claim number, procedure code, rendering provider number.
- Receive updates to Claim Adjustment Reason Codes and Remittance Advice Remark Codes three times a year. Physicians and suppliers can sign up on their Carrier or DMERC website to be notified of these updates.
- Eliminates physical filing and storage space needs.

MREP software information (including how to obtain a free copy) is available on Medicare contractor websites. To learn more about the new MREP software and how to receive the HIPAA 835, physicians and suppliers should contact their Medicare carrier or DMERC. Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/> on the CMS website.

For your reference, a Special Edition Medlearn Matters article (SE0611) is available at: <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0611.pdf> .

\* This includes physicians, providers, suppliers, and qualified non-physician practitioners that bill Medicare Carriers, including DMERCs.

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### **Do You Have a Hospital Outpatient Coding Question?**

In a joint effort to improve billing and data quality, the American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) have joined together in establishing the AHA clearinghouse to handle coding questions on established Healthcare Common Procedure Coding System (HCPCS) usage. The American Health Information Management (AHIMA) will also provide input through the Editorial Advisory Board.

The clearinghouse will serve as a centralized point of contact to educate hospitals, policy makers and the public on HCPCS coding. Hospitals and health care professionals have experienced a growing need for greater consistency and improved understanding of HCPCS coding in the wake of implementation of prospective payment methods that utilize HCPCS coding for billing and payment purposes.

The AHA's Central Office will handle the clearinghouse functions and provide open access to any person or organization that has questions regarding a subset of HCPCS coding, particularly hospitals and other health professionals who bill under the hospital outpatient prospective payment system (OPPS). Inquiries on the application of level I HCPCS codes (CPT-4) for physicians will be referred to the American Medical Association. Level II HCPCS codes related to durable medical equipment, prosthetics, orthotics, and other supplies should be referred to Durable Medical Equipment Regional Carriers (DMERCs) or their successors, the DME Medicare Administrative Contractors (MACs).

HCPCS-related questions must be submitted in the approved form, which you can download from the AHA website at [www.ahacentraloffice.org](http://www.ahacentraloffice.org), and either faxed or mailed directly to the AHA Central Office. Be advised that it is difficult to provide coding responses to generic scenarios without specific information. Refer to the form for additional information that should be submitted with your coding question(s).

The mailing address and fax number for HCPCS-related questions are as follows:

Central Office on HCPCS  
American Hospital Association  
One North Franklin

Chicago, IL 60606  
Fax: 312-422-4583

Coding question information is also available at [http://www.cms.hhs.gov/MedHCPCSGenInfo/20\\_HCPCS\\_Coding\\_Questions.asp](http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp) on the CMS website. For general HCPCS information, go to <http://www.cms.hhs.gov/MedHCPCSGenInfo/> on the CMS website.

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CMS has revised the **HHABN and pertinent instructions**. HHAs will have up to 90 days to change from use of the former version of the HHABN to the new revised notice, which has an Office of Management and Budget (OMB) approval date of "01/2006" in its lower left hand corner. CMS has posted the revised HHABN in English and Spanish on its website at:

[www.cms.hhs.gov/BNI/](http://www.cms.hhs.gov/BNI/)

Go to the left-hand margin on this page and click on the link for FFS HHABN.

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**Here are some recently-released Medlearn Matters articles related to the Deficit Reduction Act:**

MM4313 - 2006 Physician Fee Schedule Payment Rate  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/mm4313.pdf>

MM4282 - Home Health Temporary 5% Payment Increase  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4282.pdf>

MM4349 - No Payments (Hold on Payments 9/22-9/30)  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4349.pdf>

MM4284 - Adding two days to Paper Claim Payments  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/mm4284.pdf>

MM4346 - Second Participation Enrollment Period for 2006  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/mm4346.pdf>

MM4291 - ESRD Payment Rates  
<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4291.pdf>

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*Enjoy your weekend ~ Valerie*

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On Wednesday, Secretary Mike Leavitt, released the second progress report on the Medicare prescription drug benefit.

"We are now in the 53rd day since implementation of Medicare prescription drug coverage. After reviewing the numbers and experiences to date, I can report that we are seeing solid progress. But we are not done. We continue to work aggressively to solve problems that inevitably occur in transitions this size".

The report is attached and can also be found at:  
<http://www.hhs.gov/medicare2final.pdf>



Two-month report  
HHS 022206.pd...

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Attached is the updated "A National Conversation---Friends and Family First" toolkit. The document is posted on the homepages of the [medicare.gov](http://www.medicare.gov) and [cms.hhs.gov](http://www.cms.hhs.gov) websites. The document takes you through the five simple steps to joining a Medicare prescription drug plan.

- Step 1: Understand the Basics
- Step 2: Consider current coverage
- Step 3: Gather information and compare plans
- Step 4: Get help with your plan choices
- Step 5: Enroll



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A new fact sheet, describing the recent extension of transitional drug coverage to 90 days, can be found at <http://www.medicare.gov/Publications/Pubs/pdf/11193.pdf> on the web.

On February 1, HHS Secretary Mike Leavitt announced that plans would be extending the 30-day transitional drug coverage period, extending it from the 30-day period to an

additional sixty (60) more days. That means that the plans are providing a full ninety (90) days of drug coverage (through March 31, 2006).

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Attached below is a new Fact Sheet publication entitled "What Drugs do Medicare Drug Plans Cover?" This CMS publication #11194 is available on [www.medicare.gov](http://www.medicare.gov) under Publications.



11194.pdf (295 KB)

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The Centers for Medicare & Medicaid Services has assembled a fact sheet for use in prescriber's offices regarding the new transition policy, as well as the exceptions and appeals process for the Medicare Prescription Drug Benefit. This resource fact sheet is designed to provide ready-links to tools that will streamline the prescribing process under the new benefit. We continue to work with groups representing physicians, pharmacists, patients and Part D plans to simplify and standardize the information that physicians need to provide to plans.

We have consolidated most of the resources for prescribers into the provider web site at [www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp) where offices can get access to direct phone numbers to the plan's coverage determination people, as well as copies of model forms that will help speed the process. Of course, information is always available through our Medicare Learning Network at [www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp).

We are hopeful that you will share this fact sheet with your members and feature it in your electronic and print outlets so that as many prescriber's offices know about the processes and tools we have designed to make it easier for them and their patients.



Part D Resource  
Fact sheet (2)...

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**In conjunction with the release of the above-mentioned Fact Sheets**, CMS invites your participation in a Medicare Prescription Drug Coverage audio/training conference call titled:

*"Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions"*

This presentation will cover the topics included in the fact sheets.

**Please Save This Date: March 2, 2006, 2:30- 3:15 PM EST**

**The procedure to connect to this audio/conference is as follows:**

**Call in toll free number:** 1-888-469-1340 (please call in 15 minutes before the call is scheduled)

**Participant pass code:** # 2385428

**Call Leader:** Charlotte Newman

You may view/download the PowerPoint Presentation on Tuesday, February 28th after 3:00 PM EST on our Partner Center website <http://www.cms.hhs.gov/center/partner.asp> under SPOTLIGHT.

If after reviewing the PowerPoint presentation and/or the attached fact sheet you have questions, you may submit them in advance, to [BSPGtraining@cms.hhs.gov](mailto:BSPGtraining@cms.hhs.gov) by Wednesday, March 1, 2006, by 12:00 Noon and reference in the subject line- 3/2/06 Training.

**This session will be recorded and be available approximately 1 week following the training on <http://media.cms.hhs.gov/cms/partner03022006.wma>.**

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## **MORE THAN 25 MILLION MEDICARE BENEFICIARIES NOW HAVE PRESCRIPTION DRUG COVERAGE**

The number of Medicare beneficiaries receiving prescription drug coverage continues to grow with more than 25 million Medicare beneficiaries now covered, well on track toward the goal of 28 to 30 million enrollees in the first year. This number reflects more than 5.3 million beneficiaries who have signed up individually for prescription drug coverage in the last three months, including 1.5 million who signed up in the last 30 days. Most of the new enrollees in stand-alone drug plans chose plans offering other than the “standard” drug benefit. Many beneficiaries chose coverage with low or no deductible, fixed copays for most prescriptions instead of coinsurance, or coverage in the coverage gap or “donut hole.”

More than 500,000 new beneficiaries have enrolled in the Medicare Advantage health plans since drug coverage enrollment began on Nov. 15, 2005 (415,823 since mid-January). Though many Medicare Advantage plans had some drug coverage before 2006, the coverage is now generally much more extensive and does not include caps on coverage that were common before the drug benefit. As with other benefits, drug coverage is often more generous than the basic Medicare drug benefit, and drug premiums are significantly lower. Some Medicare Advantage plans are even offering prescription coverage for no additional premium.

"The promise of the new Medicare law is being realized for more than 25 million Medicare beneficiaries who are getting help paying for the medicines they need," HHS Secretary Mike Leavitt said. "We are encouraged by the millions of people who are enrolling each month, even as we continue to reach out to those who have not yet signed up but can benefit from the new program."

Secretary Leavitt noted that those with coverage include not only those new stand-alone prescription drug plans, but also those in Medicare Advantage plans made stronger by the new Medicare law, as well as retirees who are in employer- or union-sponsored plans that are for the first time getting support from Medicare to keep their coverage more secure.

"We've seen enrollment continue at a steady pace, faster than what we saw before the late December surge," said Centers for Medicare & Medicaid Services Administrator Mark B. McClellan, M.D., Ph.D. "Any beneficiary who has questions about what the drug coverage means for them can call 1-800-MEDICARE anytime with little or no waiting, or go to [medicare.gov](http://www.medicare.gov), or get face-to-face help from one of our many partner organizations and events around the country."

CMS continues to urge Medicare beneficiaries to sign up for drug coverage early in the month before they want coverage, or at least 2 to 3 weeks before they plan to use their coverage. "Signing up before the 15<sup>th</sup> makes it more likely that you will get your prescriptions filled quickly the first time you use your coverage," Dr. McClellan said. "We want everyone to get the most out of their coverage starting the first time they go to the drug store." The enrollment period continues through May 15, 2006.

The overall drug benefit enrollment figures as of Feb. 13 are:

- Stand-alone Prescription Drug Plans: about 4.9 million (1.3 million since Jan. 13)
- Medicare/Medicaid: 6.2 million (including 560,000 in Medicare Advantage plans).
- Medicare Advantage: 4.7 million plus 560,000 in Medicare/Medicaid.
- Retiree coverage: About 6.4 million retirees are enrolled in the Medicare retiree subsidy. As previously stated, another 1 million retirees are in employer coverage that incorporates or supplements Medicare's coverage. Another estimated 500,000 retirees are continuing in coverage that is as good as Medicare's.
- TRICARE/ FEHB retirees: 3.1 million.

For more information, see the *Secretary's Progress Report II on the Medicare Prescription Drug Benefit* at <http://www.hhs.gov/secretaryspage.html>. To enroll, visit [www.medicare.gov](http://www.medicare.gov).

The attached document provides state-by-state enrollment figures.



Part D Enrollment  
as of 02.13....

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February 28, 2006

The Medicare Learning Network's latest product, "**The Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians**," is now available in both print and CD-Rom formats. This publication offers rural health information and resources in a single source and can be ordered free of charge from the Medicare Learning Network's web page at <http://www.cms.hhs.gov/medlearnproducts/> on the CMS website. Check it out!

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