

Provider Partnership Program (PPP) E-mail Notification Archives

May 1, 2006

Beginning today, **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) announces the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPIs via the web-based or paper application process. After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers. Interested health industry organizations should avail themselves of the EFI materials available from the CMS NPI page (www.cms.hhs.gov/NationalProvIdentStand/) and from the NPPES page (<https://nppes.cms.hhs.gov>) before downloading and completing the Certification Statement (available at <https://nppes.cms.hhs.gov>) and registering as EFI Organizations. A completed Certification Statement must be approved by CMS before an interested health industry organization can participate in EFI.

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The **new** Medicare Enrollment Applications (Form 855) are now available on the CMS website. Go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll/> and click on Enrollment Applications on the left side of the page. All providers and suppliers are encouraged to use the new forms immediately. Additional details will be provided via a **Special Edition MLN Matters** article in the near future--so stay tuned!

In response to questions regarding **beneficiary options for paying their Medicare prescription drug plan premium**, CMS has developed a set of materials that addresses these options and how they work. One option that beneficiaries have is to have their monthly prescription drug plan premium deducted from their monthly Social Security benefits. Other options that beneficiaries have include being billed for their monthly prescription drug plan premium directly by the plan or having their Part D premium automatically deducted from their checking or savings account.

For beneficiaries who have chosen to have their premium automatically deducted from their Social Security payment, it generally takes about two months from the time an enrollee's drug plan submits a request to the Social Security Administration (SSA) before deductions begin. As a result, most of the time, the first time premiums are withheld from the Social Security benefit, two

monthly premium payments will be withheld at the same time. Social Security will only deduct the cost of one monthly premium payment from the monthly Social Security benefit after that. **It is important to note that this has been the case from the beginning of the Part D benefit implementation and does not represent a new policy.**

In rare instances, a beneficiary's Social Security benefit may not be enough to cover two months' premiums at once. To address this issue, CMS has drafted a model letter that plans can use to contact beneficiaries to arrange another method for paying the monthly premium. **CMS has also emphasized to plans that they may not disenroll a beneficiary for non-payment of premiums if they are waiting for the Social Security deductions to begin.**

Please find attached a description of the options and answers to questions related to withholding premiums from beneficiaries' Social Security checks, as well as the model plan letter described above.



11200.pdf (378 KB)



11202.pdf (362 KB)



Plan letter
142606.pdf (14 KB) ..

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May 3, 2006

Good afternoon everyone! Provider Partnering activities are in full gear and I want to send a warm welcome to our newest partners, including the American Medical Billing Association, the American Surgical Hospital Association, and the American Academy of Ophthalmology. This note includes information on:

- * The availability of Special Edition MLN Matters Articles regarding DME Medicare Administrative Contractors' Implementation and the release of the revised CMS-855 Enrollment Form;
- * The availability of the Medicare Learning Network's Remittance Advice Guide in CD-ROM format;
- * Payment Changes for Long-Term Care Hospitals for Rate Year 2007; and
- * Payment Increases and policy changes for Inpatient Psychiatric Facilities.

Hope your week is going well so far.

New Special Edition MLN Matters Articles

SE0628 - DME MAC NEWS #1 - DME Medicare Administrative Contractors'
Implementation – Information for Suppliers
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf>

SE0632 - Announcing the Release of the Revised CMS-855 Medicare Enrollment
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf>

The *Medicare Learning Network* is pleased to announce that *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* is now available on CD ROM. Copies of this CD ROM may be ordered, free of charge, through the Medicare Learning Network's (MLN) Product Ordering Page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website. This publication may also be downloaded and viewed online at the following url <http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061410> on the MLN Publications page. The web version of the "RA Guide" may be reprinted or redistributed as needed. Hard copies of the "RA Guide" will be available later this Spring.

MEDICARE ANNOUNCES PAYMENT CHANGES FOR LONG-TERM CARE HOSPITALS FOR RATE YEAR 2007

The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule designed to assure appropriate payment for services by long-term acute care hospitals (LTCHs) to severely ill or medically complex patients, while providing incentives for more efficient care for Medicare beneficiaries. Under this final rule, Medicare payments to LTCHs are expected to be \$5.3 billion for rate year (RY) 2007. The final rule, which will appear in the May 12, 2006, *Federal Register*, will be effective for discharges occurring on or after July 1, 2006 through June 30, 2007.

Attached is the entire Press Release.



PR10.LTCH.Final.05
.02.06.pdf (...)

To view the display copy of CMS-1485-F, go to <http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/CMS-1485-F.pdf> on the CMS website.

For additional information, go to <http://www.cms.hhs.gov/LongTermCareHospitalPPS>.

MEDICARE PROVIDES PAYMENT INCREASE, POLICY CHANGES FOR INPATIENT PSYCHIATRIC FACILITIES

Inpatient psychiatric facilities (IPFs) will receive an average 4 percent increase in Medicare payments, beginning in July. The higher payments, for discharges occurring July 1 or later, will be under a final rule recently announced by the Centers for Medicare & Medicaid Services (CMS). This increase includes the effects of market basket updates resulting in a 4.5 percent increase in total payments for Rate Year 2007, July 1, 2006 to June 30, 2007. The market basket shows how much the costs of goods and services used by a particular industry have changed over time.

Within this average, government-operated psychiatric hospitals receive the largest share of the total increase. The final rule also includes several changes in payment policies for these facilities.

The IPF PPS rule went on display May 1st at the Federal Register. It can be viewed at: http://www.cms.hhs.gov/InpatientPsychFacilPPS/Downloads/CMS-1306-F_5-01-06.pdf.

More information is available at <http://www.cms.hhs.gov/InpatientPsychFacilPPS/>.

Best regards ~ Valerie

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May 4, 2006

I sincerely apologize but it seems I gave you the incorrect link for the Special Edition MLN Matters article announcing the release of the revised CMS-855 Medicare Enrollment Applications. The correct link for this article (# SE0632) is

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf>

Once again, I apologize for any inconvenience ~ Valerie

May 4, 2006

The Centers for Medicare & Medicaid Services (CMS) recently issued a memorandum to Part D plan sponsors on contingency planning for the May 15, 2006 Initial Enrollment Period (IEP) deadline. CMS is reaching out to its plan partners to ensure that they are prepared to deal with anticipated increases in enrollment volume and that new enrollees will be able to obtain prescription medications on June 1, 2006.

CMS is continuing to stress to beneficiaries and partner organizations the importance of enrolling in Part D as soon as possible. We also are taking a number of steps to deal with the likelihood of

a last-minute surge in enrollment, such as operating additional 1-800-MEDICARE call center sites and having call center staff work through 3:00 a.m. EDT on May 16 to accept enrollments.

CMS has instructed plan sponsors to make similar preparations for responding to enrollments between now and May 15, as detailed in the attached memo. Plans must have procedures in place to accept mailed applications postmarked on or before May 15, 2006. Incomplete applications received by May 15 will be treated as complete for purposes of meeting the IEP deadline.



May 15 enrollment
contingency-...

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May 5, 2006

The Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on May 8, 2006 and conclude on June 2, 2006. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. If physicians are interested in electing into CAP starting July 1, 2006, they must submit a Physician Election form to the local carrier **between May 8 and June 2.**

In conjunction with the election period, the Centers for Medicare & Medicaid Services (CMS), along with Noridian Administrative Services (NAS), will host an **"Ask the Contractor"** teleconference for physicians and their staff to ask questions regarding CAP. This call will provide an opportunity to learn more about the program and how to participate. The call will take place on the following date:

Date: **Thursday, May 11, 2006, 1:00-2:30 p.m. EST**
Title: **Ask the Contractor Teleconference for CAP**
Call in Number: **1-866-216-6835**
Access Code: **329694**

Participant information:

- Please dial in 5 minutes prior to conference start time.
- Enter your access code, followed by the pound (#) sign.
- Your line will be placed on hold with music until conference starts.

Additional information about the CAP is available at the following website:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp#TopOfPage .

Additional information for physicians, including the physician election form is at
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage .

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage .

Please note that completed and signed physician election forms should be returned by mail to your local carrier. **Forms must be postmarked on or before June 2, 2006.**

More detailed information will be available in an upcoming *MLN Matters* article.

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May 10, 2006

New Medicare Preventive Services Product

A new brochure titled *Smoking and Tobacco-Use Cessation Counseling Services* is now available to view as a download at <http://www.cms.hhs.gov/mlnproducts/downloads/smoking.pdf> on the Medicare Learning Network's (MLN) Publications page. Copies of this brochure, for health care professionals, may be ordered free of charge from the MLN Product Ordering page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

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Coding Drug Administration Services for Payment Under the CY 2006 OPPS

CMS issued Transmittal 785 (Change Request 4258), on December 16, 2005 to revise Chapter 4, Section 230 of the Medicare Claims Processing Manual (Pub. 100-04). The manual revision updated payment policies for drug administration services furnished

under the Hospital Outpatient Prospective Payment System (OPPS) effective January 1, 2006. In response to requests for further clarification of correct coding for drug administration services paid under the OPPS, CMS further revised Chapter 4, Section 230 of the Medicare Claims Processing Manual in Transmittal 902 (Change Request 4388), issued on April 7, 2006. The link to these transmittals is:
<http://www.cms.hhs.gov/Transmittals/2006Trans/list.asp> .

Transmittal 896, Change Request 5011, issued on March 24, 2006, instructed fiscal intermediaries to implement Version 12.0 of Correct Coding Initiative (CCI) edits for drug administration services paid under the OPPS that are furnished on or after April 1, 2006. When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Rather, only one line item is rejected. That is, the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures.

Hospitals have raised particular concerns about the impact of CCI edits when the following code pairs are reported on the same claim for the same date of service without modifier -59. Because these codes represent services which may be frequently furnished together during a single outpatient encounter, hospitals report that they would have to review virtually every outpatient claim to manually add modifier -59 so that claims with these code pairs would process to payment without triggering a CCI edit.

Column 1	Column 2
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

CMS is currently working to resolve as swiftly as possible concerns that have been raised by numerous hospitals about the impact of CCI edits on reporting these particular code pairs. CMS will announce on the CMS website, through the hospital listserv, through contractors, and through other communication channels the steps it is taking to address the issues raised by hospitals in connection with these particular CCI edits. Hospitals are encouraged to await instructions from their fiscal intermediary before modifying internal billing processes.

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May 12, 2006

Clarification to the 5/9/06 IPF PPS Final Rule

In the IPF PPS Final Rule published on Tuesday May 9, 2006 (71 FR 27040), there were two typographical errors that we wanted to clarify:

First, on page 27069, in the response to the comment in the third column, we incorrectly state that "IPFs that did not train interns and residents during the time period of the IPF's most recent cost report filed before November 15, 2005 would receive an FTE cap of 'zero'." The correct date that should be referenced is November 15, **2004**, as stated in the regulations text at § 412.402 (definition for New GME program).

Second, in Addendum C, in Table 1, beginning on page 27134, and in Table 2 on page 27156, we display the wage index tables by CBSA. We would like to clarify that these are the **final** wage index values for RY 2007 effective July 1, 2006, and not the proposed values as indicated by the titles on the tables.

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Payment Rates for Inpatient Rehabilitation Facility Services

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment rates for services by inpatient rehabilitation facilities (IRFs) and modify payment policies for fiscal year (FY) 2007. The proposed policies, if finalized, are estimated to increase Medicare payments to approximately 1,240 IRFs in FY 2007 by \$40 million. The new payments and policies would apply to discharges on or after October 1, 2006, through September 30, 2007.

A display copy is available on the CMS IRF PPS website at
<http://www.cms.hhs.gov/InpatientRehabFacPPS/downloads/cms1540p-display050806.pdf>

For publication details, please visit the Office of the Federal Register's website at
<http://archives.gov/federal-register/public-inspection/>.

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Funding Available for Services to Undocumented Aliens

Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens – An Update:

*Physicians, hospitals and ambulance services that provide emergency health services to undocumented aliens should be aware that The Medicare Prescription Drug Improvement and Modernization Act (MMA) (Section 1011) provides \$250 million **each year, for Fiscal Years (FY) 2005-2008**, for payments to eligible providers for emergency health services given to undocumented and other specified aliens. **You may not be receiving funds that are available to you** for services you furnish to undocumented aliens. We have prepared a Special Edition article to inform and/or remind you about these available funds. Please click on the following url for more details:*

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0633.pdf>

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Medicare Prescription Drug & Other Beneficiary-Related News

TIME IS RUNNING OUT AS THE MAY 15th ENROLLMENT DEADLINE NEARS

People With Medicare Urged To Enroll in Drug Benefit Before Deadline Rush

Medicare and its partners has been holding more than 1,000 enrollment events all over the country this week to help people with Medicare enroll in a prescription drug plan before the May 15th deadline. In addition to the availability of thousands more volunteers at State Health Insurance Assistance Programs (SHIPs) and many other advocacy and support organizations for seniors and people with a disability, Medicare has had 6,000 customer service representatives and enhanced online support available. To view the entire press release, click the HHS press release link below: <http://www.hhs.gov/news/press/2006pres/20060508.html>

The Centers for Medicare & Medicaid Services (CMS) announced that over a million more people have enrolled in prescription drug coverage between late April and May 6, bringing the total of beneficiaries with prescription drug coverage to 37 million. This number includes about 9 million individual enrollees in "stand alone" prescription drug plans and more than 1 million new enrollees in Medicare Advantage plans. It also includes the estimated 5.8 million Medicare beneficiaries

who receive drug coverage from the Veterans Administration and other sources of coverage equal to Medicare. Read the rest of the story in the attached Press Release.



Medicare
lease0510.pdf (76 K)

Remember--**all people with Medicare are eligible for this benefit** regardless of income or how many prescriptions they currently take. Important facts about the May 15 deadline are detailed in a fact sheet, which is available on the CMS Website at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1853>.

Finally, CMS' Partner Tip Sheet on the "Drug Plan Enrollment Deadline" is now posted on the CMS Partner Center website in the "Fact Sheets/Tip Sheets/Mailings" section at the following link:

<http://www.cms.hhs.gov/partnerships/downloads/DrugPlanEnrollmentDeadline.pdf>

I have also attached a copy of the document for your convenience.



DrugPlanEnrollment
Deadline.pdf...

Beneficiary Booklet on Medicare Rights and Protections Now Available

Medicare is committed to helping beneficiaries get the services they need, when they need it most. The Centers for Medicare & Medicaid Services would like to announce the release of an electronic version of "**Your Medicare Rights and Protections**" that clearly outlines the key safeguards governing the original Medicare plan, Medicare Health plans and the Medicare Drug plans.

This booklet has information that beneficiaries and advocates need to know in order to file a complaint, appeal or identify where to go to get help with questions. This easy to understand publication outlines the basic Medicare rights, including to:

1. Be treated with dignity and respect at all times.
2. Be protected from discrimination.
3. Get information about Medicare that you can understand to help you make health care decisions.
4. Have your answers about the Medicare Program answered.
5. Get culturally competent services.
6. Get emergency care when and where you need it.
7. Learn about all of your treatment choices in clear language that you can understand.
8. Ability to file a complaint.
9. Ability to appeal a decision relating to your claims for benefits.
10. Have your health information that Medicare collects about you kept private.
11. Know your health information privacy rights.

The publication can be obtained electronically by going to:

<http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>. Answers to your questions are available 24/7 at 1-800-MEDICARE (1-800-633-4227) or TTY1-877-486-2048.

Social Security Information

The following two fact sheets are now available on the Medicare.gov website:

Medicare Drug Plans: Withholding Premiums from Your Social Security Payment - 11200

<http://www.medicare.gov/Publications/Pubs/pdf/11200.pdf>

What You Should Know About Social Security Premium Withholds - 11202

<http://www.medicare.gov/Publications/Pubs/pdf/11202.pdf>

I have also attached the files for your convenience.



11200.pdf-Medicare Drug Plans ...



11202.pdf-What You Should Know...

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New Educational Products from the Medicare Learning Network!

Happy Friday, everyone! First, let me apologize for the plethora of e-mails I have already sent out this morning, but there is just so much going on right now in the Medicare Program!

Secondly, I am very pleased to announce that we have several new provider education products available from the Medicare Learning Network (MLN) ~ the brand name for official CMS fee-for-service physician, provider, and other health care professional educational products. Remember that all MLN products are free of charge and can be ordered or downloaded from the MLN Web page at <http://www.cms.hhs.gov/MLNProducts>. I have also included some recently released MLN Matters articles that I thought might be of particular interest to you. Take a look at what's new:

Preventive Services Web-Based Training Course

The **Medicare Preventive Services: Part 3 Expanded Benefits** web-based training (WBT) course is now available. This WBT provides information about Medicare's coverage for the three new services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), diabetes and cardiovascular disease screenings. The course also includes information on diabetes self management training, medical nutrition therapy and other diabetes supplies, colorectal, prostate, and glaucoma screenings and bone mass measurements. The information presented in this course will be helpful for physicians, nurses, medical administrators and other health care professionals who provide these preventive services and screenings to Medicare patients. This course is the third in a series of three web-based training courses developed by CMS as part of a comprehensive program designed to promote awareness and increase

utilization of preventive benefits and to help those who bill Medicare for these services to file claims effectively.

The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington DC 20006. CMS has awarded .2 of CEU's to participants who successfully complete this program. The authors of this program have nothing to disclose.

You can access the Medicare Preventive Services Series: Part 3 Expanded Benefits WBT at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1

Reference Guide for Medicare Institutional Providers Who Submit Part B Claims

The ***Reference Guide for Medicare Institutional Providers Who Submit Part B Claims*** is now available on the Medicare Learning Network at www.cms.hhs.gov/MLNGenInfo/. The guide contains a variety of information to help institutional providers submit accurate and timely Medicare claims. While providing historical information on Medicare Part A, Medicare Advantage, and a brief introduction to the new Medicare Part D drug coverage benefits, this guide is focused on providing information and procedures for institutional entities that provide Part B services in addition to, or instead of, Part A services.

Rural Health Fact Sheets

The Medicare Learning Network's ***Rural Health Fact Sheet Series*** is now available in print format. The series includes information on the following topics:

- * Rural Referral Centers
- * Medicare Disproportionate Share Hospitals
- * Rural Health Clinics
- * Critical Access Hospital Programs
- * Federally Qualified Health Centers
- * Sole Community Hospitals

You can obtain copies of these fact sheets, free of charge, from the Medicare Learning Network Product Ordering Page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

And just a reminder about these previously-announced MLN Products ~

The ***Medicare Learning Network*** is pleased to announce that ***Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers*** is now available on CD ROM. Copies of this CD ROM may be ordered, free of charge, through the Medicare Learning Network's (MLN) Product Ordering Page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website. This publication may also be downloaded and viewed online at the following url <http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061410> on the MLN Publications page. The web version of the "RA Guide" may be reprinted

or redistributed as needed. Hard copies of the “RA Guide” will be available later this Spring.

A new brochure titled *Smoking and Tobacco-Use Cessation Counseling Services* is now available to view as a download at <http://www.cms.hhs.gov/mlnproducts/downloads/smoking.pdf> on the Medicare Learning Network's (MLN) Publications page. Copies of this brochure, for health care professionals, may be ordered free of charge from the MLN Product Ordering page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

Recently Released MLN Matters Articles

New:

MM5032 - Medicare Remit Easy Print (MREP) Update

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5032.pdf>

SE0631 - Critical Access Hospital (CAH) Claims

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0631.pdf>

SE0633 - Section 1011: Federal Reimbursement of Emergency Health Services

Furnished to Undocumented Aliens – An Update

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0633.pdf>

SE0634 - Facilitating Your Medicare Enrollment

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0634.pdf>

MM5047 - Full Replacement of CR4349, Hold on Medicare Payments. CR4349 Is Rescinded

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf>

MM4404 - MMA - Competitive Acquisition Program (CAP) for Part B Drugs Physician Election

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf>

MM4014 - Changes Conforming to Change Request 3648 (CR3648) for Therapy Services

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4014.pdf>

Revised:

MM4064 - MMA - Competitive Acquisition Program (CAP) for Part B Drugs - Coding, Testing, and Implementation

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>

MM4309 - MMA - Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>

I hope you all have a wonderful weekend and a Happy Mothers Day, as applicable!

Valerie

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May 15, 2006

Educational Event on Physician Voluntary Reporting Program



Presents: **Free!** Teleconferences!

“Physician Voluntary Reporting Program ”

When: 1:00 – 2:00 PM, ET, Wednesday, May 17, 2006

This presentation will provide a detailed overview of the Physician Voluntary Reporting Program (PVRP). Come and learn why you should participate.

PRESENTER: David Nilasena, MD, Centers for Medicare & Medicaid Services, Dallas Regional Office

SPECIAL NOTE: Please call 877-203-0044 fifteen minutes prior to call start time and provide the conference ID number - 8166913

Prior to the teleconference the PowerPoint Presentation will be posted at
www.sharpworkgroup.com

Call sponsored by CMS Regions IV and VI

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Acute Inpatient Hospital News

Two items of particular interest to our Hospital Partners ~

- 1) Hospital Inpatient PPS Implementation of the FY 2007 Occupational Mix Adjustment to Wage Index
- 2) Data and Information for the FY 2007 Hospital Inpatient Prospective Payment System Proposed Rule

Hospital Inpatient PPS Implementation of the FY 2007 Occupational Mix Adjustment to Wage Index

On April 3, 2006, in *Bellevue Hosp. Ctr v. Leavitt*, the Court of Appeals for the Second Circuit (“the Court”) ordered the Centers for Medicare & Medicaid Services (CMS) to apply the occupational mix adjustment to 100 percent of the wage index effective for Federal fiscal year (FY) 2007. The Court required CMS to “immediately ... collect data that are sufficiently robust to permit full application of the occupational mix adjustment.” The Court also required that all “data collection and measurement and any other preparations necessary for full application should be complete by September 30, 2006, at which time we instruct the agency to immediately apply the adjustment in full.”

To comply with the court’s order, we are issuing a proposed rule to modify the methodology and data used to calculate the occupational mix adjustment for the FY 2007 Hospital Inpatient Prospective Payment System (IPPS) proposed wage index (71 FR 24075, April 25, 2006). This proposed rule would revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new data collected on the 2006 Medicare Wage Index Occupational Mix Survey (Form CMS-10079 (2006)). This proposed rule also proposes to modify hospitals' procedures for withdrawing requests to reclassify for the FY 2007 wage index and for supplementing the FY 2008 reclassification application with official data used to develop the FY 2007 wage index. In addition, we are proposing to replace in full the descriptions of the data and methodology that would be used in

calculating the occupational mix adjustment discussed in the FY 2007 IPPS proposed rule.

There will be a 30-day public comment period on this new proposed rule that coincides with the close of the IPPS comment period on June 12, 2006.

The display version of CMS-1488-P2 can be found at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p2.pdf> on the CMS website. For additional IPPS information, go to http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp on the CMS website.

Data and Information for the FY 2007 Hospital Inpatient Prospective Payment System Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) routinely includes data in its rules so that affected parties can analyze proposed changes. We have been working with our partners to help them understand the changes being proposed to Medicare's inpatient rates for FY 2007. Since the release of the FY 2007 Hospital Inpatient Prospective Payment System (IPPS) rule, CMS has produced a number of Fact Sheets, convened two Open Door Forum (ODF) calls and another call for analysts and investors to discuss provisions of the rule, and provided a number of notifications through our listservs on available information. On the Friday, May 5, 2006 ODF, a number of questions were raised regarding access to the information that would permit hospitals and others to analyze the proposals in the rule to adopt hospital-specific cost weights for FY 2007 and consolidated severity DRGs for FY 2008 (or earlier). Given these ongoing questions, CMS would like to list once again the information that has been made available to assist the public in understanding our proposals and urge hospital analysts to study the effects of the proposed rule on their institutions. Among other information, the web site includes the following:

- Provider Specific File
- Impact file for IPPS FY 2007 Proposed Rule
- Cost to Charge Ratios (CCRs) and Weighting Factors
- DRG Relative Weights
- Consolidated severity adjusted DRG HSRVcc relative weights
- CAH List for FY 2007 Proposed Rule

All of this information and more is available at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage>:

In addition to this information, CMS makes available for purchase the Expanded Modified MedPAR data that were used in simulating the policies in the IPPS proposed rule. If readers have already ordered the proposed rule data, we are in the process of filling the orders and will be providing the FY 2005 MedPAR data that were used to model the proposed changes to the DRGs and relative weights for FY 2007 as well as the FY 2004 MedPAR data that we used to model the consolidated severity adjusted DRGs

that we are proposing to implement in FY 2008 (if not earlier). Information on how to order this information was provided in a listserv notice on April 12, 2006 and detailed in the proposed rule. If readers have not ordered the proposed rule MedPAR data, but are interested in receiving them, we encourage them to order the data as soon as possible by following the directions provided below. We will process orders in the order they are received.

For information on how to order the Expanded Modified MedPAR, go to the following Web site:

<http://www.cms.hhs.gov/LimitedDataSets/> and click on "MedPAR Limited Data Set (LDS) - Hospital (National)." This Web page will describe the file and provide directions to further detailed instructions for how to order. Persons placing orders must send the following: Letter of Request, LDS Data Use Agreement and Research Protocol (see Web site for further instructions), LDS Form, and a check for \$3,655 to:

Centers for Medicare & Medicaid Services,
Public Use Files,
Accounting Division,
P.O. Box 7520,
Baltimore, MD 21207-0520.

Given the changes we are proposing, we believe that hospitals would be interested in understanding how a given case would be assigned to a consolidated severity-adjusted DRG under the new system. In order to facilitate understanding of the underlying severity DRG concepts and logic, we are providing a link below to 3M's Web site for the duration of the comment period where users can access information related to the proposed consolidated severity-adjusted DRGs. Users will have access to a tool that allows them to build case examples using this proposed DRG classification system. The report produced by the tool will provide a detailed explanation of how the severity of illness was assigned and the diagnostic and demographic factors affecting that assignment. In addition, users will be able to view the APR DRG Definitions Manual, a report showing the mapping from the standard APR DRGs to the consolidated severity-adjusted DRGs, a report showing basic APR DRG statistics, and other APR DRG background and educational materials. This site can be accessed at: <http://www.aprdrassign.com>.

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May is National Osteoporosis Awareness and Prevention Month

In conjunction with the observance of National Osteoporosis Awareness and Prevention Month, the Centers for Medicare & Medicaid Services would like to take this opportunity to remind health care professionals that Medicare provides coverage of **bone mass measurements** once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.

Osteoporosis (often called the “silent disease” because bone loss occurs without symptoms) is responsible for an estimated 1.5 million fractures annually – an event that often leads to a downward spiral in physical health and quality of life, including losing the ability to walk, stand up, or dress, and can lead to premature death. 20 percent of senior citizens who suffer a hip fracture die within 1 year.

According to the US Surgeon General’s 2004 report *Bone Health and Osteoporosis: A Report of the Surgeon General*, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the United States could double or triple by the year 2020. The report found that many patients were not being given appropriate information about prevention; and many patients were not having appropriate testing to diagnose osteoporosis or establish osteoporosis risk.

What can you do? National Osteoporosis Awareness and Prevention Month presents an excellent opportunity for you to promote prevention, detection, and treatment of osteoporosis.

- 1) Become familiar with Medicare’s coverage for bone mass measurements;
- 2) Talk with your patients about their risks for osteoporosis and prevention; and
- 3) Encourage utilization of bone mass measurements for eligible Medicare patients.

Osteoporosis can be prevented. As a health care professional, you play a critical role in helping your patients maintain strong, healthy bones throughout their life. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and encouraging the utilization of bone mass measurements for eligible Medicare patients.

For More Information

Special Edition MLN Matters Article SE0630

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf> ~ provides information about the array of preventive services and screenings for which Medicare provides payment and lists the many resources developed by CMS to educate health care professionals about these services.

U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Office of the Surgeon General, 2004. This document can be downloaded at <http://www.hhs.gov/surgeongeneral/library/bonehealth/> on the Department of Health and Human Services website.

The National Osteoporosis Foundation www.nof.org ~ to learn more about National Osteoporosis Awareness and Prevention Month.

Thanks for your help in this worthwhile endeavor!

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Medicare Rx Update

Enrollment numbers are impressive as today's deadline nears...

Today is the last day of the initial enrollment period for Medicare Prescription Drug program and the level of activity is impressive. In the past few days nearly 600,000 additional people with Medicare have signed up for prescription drug coverage and this past weekend saw five times as many people enroll on line as any other previous weekend. We have staffed 1-800-MEDICARE with over 6,000 customer service representatives to eliminate significant wait times, and we have hundreds of our own expert staff to help as well.

To help facilitate smooth enrollment in these last hours before the midnight deadline, please ask beneficiaries to follow the three simple steps... have your Medicare card handy, line up your current prescriptions, and either call 1-800-MEDICARE for personalized assistance over the phone or go online www.medicare.gov to enroll. Over 40,000 users at a time have used www.medicare.gov with no wait time. In addition, they may attend one of the hundreds of events our partners are holding across the country today. Remember, even if beneficiaries do not have prescription drug needs now, we encourage them to choose a plan so they will have the coverage they need if something happens in the future. They can always pick a low priced plan... peace of mind is worth the small investment.

We are very pleased that so many have enrolled. Thanks to the work of so many partners, and pharmacists in particular, we have a real opportunity of ensuring that 90% of people with Medicare have some form of prescription drug coverage.

Reminder...today is the last day of the drug card program

Please see the attached guidance to pharmacists concerning the end of the Medicare Prescription Drug Discount Card Program. All Medicare-approved Drug Discount Card sponsoring organizations have been informed that access to discounts and transitional assistance must be available to beneficiaries through 11:59p.m. local time on May 15, 2006. Thereafter, all Medicare Prescription Drug Discount Card benefits (both discounts and transitional assistance) must be discontinued and discount cards deactivated. Please note that this does not apply to pharmaceutical manufacturer or state patient assistance programs.

CMS recognizes that pharmacies may get former Drug Card members attempting to use their Drug Card following the conclusion of the Drug Card program. Pharmacists should notify the beneficiary that the Drug Discount Card program has ended, and refer the beneficiary to the Customer Service department of their Drug Card, or to 1-800-MEDICARE.



End of Program
Guidance for Ph...

May 17, 2006

I would like to extend my warmest thanks to all of you who helped CMS spread the word about the Medicare Prescription Drug Coverage Program. As you can see from this notice, your efforts helped lead to a very positive result!

ENROLLMENT ACTIVITY ON MAY 15th

Hundreds of thousands of people with Medicare took action on May 15 to enroll in Medicare prescription drug plans before the close of the initial enrollment deadline, which ended at midnight yesterday. There was also an unprecedented level of interest and enrollment leading up to the 15th as evidenced by the thousands of local enrollment events, more than 2.2 million calls to 1-800-MEDICARE, historic level of online enrollments and more than 15 million page views on www.medicare.gov.

Based on 872,000 enrollments from last week that have already been processed, as well as clear indications of strong enrollment activity in the final days before the deadline, significantly more than a million additional beneficiaries have Medicare drug coverage since our last announcement of more than 37 million beneficiaries with coverage on May 9.

As a result, while we are still tabulating final enrollment numbers, more than 38 million people with Medicare -- **representing more than 90 percent of all beneficiaries** -- now have coverage for prescription drugs.

For more information on the Medicare prescription drug plan May 15th enrollment click here to read the recently-issued CMS Fact Sheet:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1858>

Thanks again ~ Valerie

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May 19, 2006

Happy Friday Everyone! As we bring this work week to a close, I'm sending you this e-mail with information on the following topics:

- * An Interim Report to Congress on Physician Self-Referral
- * A Special Open Door Forum on Competitive Acquisition for Certain DMEPOS
- * A Conference Call on Medicare Preventive Services and Prescription Drug Coverage
- * A Notice of Meeting for Electronic Prescriptions for Controlled Substances

Physician Self Referral

An Interim Report to Congress was released on 5/9/06. The report is available at: http://www.cms.hhs.gov/PhysicianSelfReferral/03_DRA_Reports.asp on the CMS website.

To view the press release, go to <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1857> on the CMS website.

COMPETITIVE ACQUISITION FOR CERTAIN DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, and SUPPLIES SPECIAL OPEN DOOR FORUM

May 23, 2006

2:00 PM – 3:30 PM (EDT)

The Centers for Medicare & Medicaid Services (CMS) will be hosting a Special Open Door Forum (ODF) on May 23, 2006 to discuss the CMS proposed rule to improve Medicare's payment for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) through a new competitive acquisition program.

The CMS proposed rule: "Competitive Acquisition for Certain Durable Medical Equipment, Orthotics, and Supplies" was published in the Federal Register on May 1, 2006. We have planned this Open Door Forum during the comment period for the proposed regulation to provide a brief overview of the provisions in the proposed rule. CMS will then moderate an open session where ODF participants on the phone will have an opportunity to interact with CMS in an informal dialog.

One of the primary goals of the ODF is general outreach. Because we are in the early stages of the rulemaking process and we will be considering the many forthcoming written public comments, we are not supplying any final policy information during this forum. The forum does not replace the public comment process discussed in the proposed

rule. Any comment on this regulations needs to be provided as outlined in the Federal Register, by the close of the comment period.

We look forward to your participation.

Open Door Participation Instructions:

There are 2 ways to participate, by phone or "in-person".

1. To participate by phone:

Dial: **1-800-837-1935** & Reference Conference ID: **8996164**

(Persons participating by phone do not need to RSVP.)

2. To participate in person:

This ODF will be conducted as an adjunct to a meeting of the DMEPOS competitive bidding Program Advisory and Oversight Committee (PAOC). Those who wish to attend the ODF in person must register for the PAOC meeting. For information on how to register, please see the CMS website at

<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/PAOCMI/list.asp>.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html> . A Relay Communications Assistant will help.

ENCORE: 1-800-642-1687; Conf. ID# 8996164

"Encore" is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conference ID beginning 2 hours after the call has ended. The recording will expire after 4 business days.

For Forum Schedule updates, Listserv registration and Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/OpenDoorForums/> .

Conference Call on Medicare Preventive Services and Prescription Drug Coverage

When: Wednesday, May 24, 2006

Time: 2:30-3:30 p.m. EDT

Topic: "Medicare Preventive Services and Update on Prescription Drug Coverage"

This session will cover what CMS is doing to foster the use of preventive services. It will describe the covered services, highlighting the importance of these benefits in maintaining the health of people with Medicare.

Now that the initial enrollment period for Medicare prescription drug coverage is over for most people entitled to Medicare, we will discuss how enrollment works for people newly entitled to Medicare, and what happens when someone already entitled to Medicare newly qualifies for the extra help for people with limited income and resources.

Call-In Procedures

Dial: (866)-811-2401 (please call in 15 minutes before session begins)

Enter pass code: # 9270299

There are a limited number of call-in lines so please share access when possible

Materials will be available to view/download Tuesday May 23, 2006, after 3PM EDT at <http://www.cms.hhs.gov/NationalMedicareYouTrain>

(Select Medicare Rx Conference Calls from Menu on left)
Archived copies from previous Medicare Rx Conference Calls can be downloaded at this same location.

Notice of Meeting on Electronic Prescriptions for Controlled Substances (as published in the Federal Register)

Federal Register: May 15, 2006 (Volume 71, Number 93)
[Notices]
[Page 28052-28054]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr15my06-70]

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. **DEA-218N**]
RIN 1117-AA61

Electronic Prescriptions for Controlled Substances; Notice of Meeting

AGENCY: Drug Enforcement Administration (**DEA**), Justice.

ACTION: Notice of meeting.

SUMMARY: The Drug Enforcement Administration (**DEA**), in conjunction with the Department of Health and Human Services (**HHS**), is conducting a public meeting to discuss electronic prescriptions for controlled substances. Specifically, this meeting is intended to allow industry-- prescribers, pharmacies, software/hardware vendors, and other interested third parties-- to address how electronic prescribing systems can meet **DEA's** prescription requirements under the Controlled Substances Act, without unduly burdening the parties to electronic prescribing transactions.

DATES: This meeting will be held **Tuesday, July 11, 2006, and Wednesday, July 12, 2006, 8:30 a.m. until 5:30 p.m.** Registration will begin at 7:30 a.m. This meeting will be held at the Marriott Crystal City at Reagan National Airport, 1999 Jefferson-Davis Highway, Arlington, VA 22202; (703) 413-5500. The meeting will take place in the Crystal Forum amphitheatre, adjacent to the hotel.

Meeting Attendance: To ensure proper handling, please reference ``Docket No. **DEA-218N**'' on all written and electronic correspondence regarding this meeting. Persons wishing to attend this meeting, space permitting, must provide attendee information to the Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, via e-mail to dea.diversion.policy@usdoj.gov, or via facsimile, (202)

353-1079, as specified below. Persons wishing to attend the meeting must provide this information to the Liaison and Policy Section no later than June 26, 2006.

Comments: All written comments will be made available at the Diversion Control Program Web site, <http://www.deadiversion.usdoj.gov> prior to the public meeting. Therefore, as this is a public meeting, confidential business information or other proprietary information SHOULD NOT be presented at this meeting.

Persons wishing to provide written comments must do so no later than June 26, 2006. To ensure proper handling of comments, please reference ``Docket No. **DEA-218N**" on all written and electronic correspondence. Written comments being sent via regular mail should be sent to the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, Attention: **DEA** Federal Register Representative/ODL. Written comments sent via express mail should be sent to **DEA** Headquarters, Attention: **DEA** Federal Register Representative/ODL, 2401 Jefferson-Davis Highway, Alexandria, VA 22301. Comments may be directly sent to **DEA** electronically by sending an electronic message to dea.diversion.policy@usdoj.gov. **DEA** will accept attachments to electronic comments in Microsoft word, WordPerfect, Adobe PDF, or Excel file formats only. **DEA** will not accept any file format other than those specifically listed here. This meeting will consist of panel presentations. There will be limited opportunities for attendees to make oral comments at the meeting.

FOR FURTHER INFORMATION, CONTACT: Mark W. Caverly, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, telephone: (202) 307-7297.

SUPPLEMENTARY INFORMATION: Many within the health care industry are encouraging the adoption of electronic prescriptions because such prescriptions would improve patient safety by eliminating medical errors that arise from misread or misunderstood handwritten prescriptions. These parties also focus on the potential cost savings, both to industry and the public, realized from, among other benefits: fewer medical errors and adverse drug events; fewer callbacks from pharmacies to practitioners to clarify handwritten prescription information; and reduced ability and opportunity to commit fraud and diversion of prescription medications. The focus of these parties is to facilitate adoption of electronic prescribing as quickly as possible to obtain the benefits that are expected to follow. Both the Drug Enforcement Administration (**DEA**) and the Department of Health and Human Services (HHS) have an interest in electronic prescribing. **DEA** is responsible for enforcing the Controlled Substances Act, including the prescribing and dispensing of controlled substances to the public by **DEA**-registered practitioners and pharmacies. Such enforcement includes the writing and signature of prescriptions and retention of prescription records. The Department of Health and Human Services has a statutory mandate to facilitate adoption of electronic prescribing. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires that ``prescriptions * * * for covered Part D drugs prescribed for Part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program" that meets the requirements of the MMA (Pub. L. 108-173). HHS is required to promulgate transmission standards for the Medicare electronic prescription drug program. HHS adopted foundation

standards regarding transmission of electronic prescriptions for covered Part D drugs prescribed for Part D eligible individuals by publication of a Final Rule which became effective January 1, 2006 (70FR 67567, November 7, 2005).

HHS also has a statutory mandate under the Health Insurance Portability and Accountability Act (HIPAA), the Administrative Simplification provisions of which require HHS to adopt standards for the electronic transmission of health information contained in certain financial and administrative transactions. HIPAA also requires HHS to adopt standards for the security of electronic health information, and, in consultation with the Department of Commerce, to adopt standards for electronic signatures for certain HIPAA transactions. These regulations and standards are applicable to all health plans (including federal health programs), healthcare clearinghouses, and all health care providers who conduct electronic transactions. Therefore, **DEA**, in conjunction with HHS, is conducting a public meeting to allow the public, including prescribers, pharmacies, software/hardware vendors, and other interested third parties, to identify electronic signature solutions for electronic prescribing which mitigate, to the greatest extent possible, any cost and burdens associated with adoption of the new technology while addressing the security and accountability requirements under the Controlled Substances Act of 1970 as they relate to controlled substances.

Specific questions which persons are encouraged to address are as follows:

- What is your perception of the current risks associated with electronic prescribing?
- How did you identify those risks?
- How does your electronic prescribing system address those risks?
- Are risks pertaining to prescriptions for controlled substances different from prescriptions for non-controlled substances?
- Please explain. What additional modifications would be necessary for your system to be used for electronic prescribing of controlled substances?
- Please be specific as to how this would be done, and the burden (cost or otherwise) this would entail.
- How does your system authenticate the person signing the prescription?
- How does your system ensure the integrity of the prescription records?
- What current and future threats (e.g., eavesdropping, man-in-the-middle attack, hijacking, impersonation) to system-wide security have you considered during your design, development, and implementation?
- If smart cards, open networks or other methods of transmission are used to facilitate electronic prescribing, can your system work within those environments? Please specifically explain how it can or why it cannot.

Meeting Participation : This meeting is open to the public. Persons and organizations representing prescribers, pharmacies, and vendors who design, develop, or market electronic prescribing software or hardware/software used to permit electronic prescribing [authenticate individuals or used to sign or secure electronic documents] may be particularly interested in this meeting provide the following information to the Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, no later than June 26, 2006 via e-mail or facsimile using the contact information listed above:

Name:-----

Title:-----

Company/Organization:-----

Address:-----

Telephone:-----

E-mail address:-----

Persons needing accommodations (e.g., sign language interpreter) are requested to notify **DEA** with their accommodation request no later than June 26, 2006. This meeting will consist of panel presentations. There will be limited opportunities for attendees to make oral comments at the meeting. Persons wishing to provide written comments may do so no later than June 26, 2006. All written comments will be made available at the <http://www.deadiversion.usdoj.gov> prior to the public meeting. Therefore, as this is a public meeting, confidential business information or other proprietary information **SHOULD NOT** be presented at this meeting. Please see the ``Comments" section above for further information regarding providing written comments.

There's a good possibility I will be sending additional messages to you today but if not, I hope you all enjoy a great weekend!

With best regards ~ Valerie

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May 22, 2006

The revised ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*** (previously titled *Medicare Resident & New Physician Guide: Helping Health Care Professionals Navigate Medicare*) is now available in downloadable format on the MLN Publication Page located at www.cms.hhs.gov/MLNProducts/MPUB/list.asp#TopOfPage on the Centers for Medicare & Medicaid Services website. The guide will be available in print format in approximately six weeks.

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May 25, 2006

Below, is the summary fact sheet on Competitive Bidding DMEPOS. To review the rule in the Federal Register, please click here:

<http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270p.pdf>

**COMPETITIVE ACQUISITION PROGRAM FOR CERTAIN
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS,
AND SUPPLIES (DMEPOS) AND OTHER ISSUES PROPOSED
RULE (CMS 1270-P)**

Overview

Providers and suppliers that furnish certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the “Medicare DMEPOS Competitive Bidding Program”). This program will improve the effectiveness of Medicare’s payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. Today the Centers for Medicare & Medicaid Services (CMS) issued a rule describing the proposed methodologies for selecting the areas in which the program will be first implemented and the items to be included in the program and for determining payments under the program, among other provisions. This fact sheet identifies some key elements but please refer to the proposed rule for a full discussion of the issues involved.

Legislative Background

Section 302(b) (1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires the Secretary to establish and implement the Medicare DMEPOS Competitive Bidding Program. This program will change the way that Medicare pays for DMEPOS under Part B of the Medicare program by utilizing bids submitted by DMEPOS suppliers to establish Medicare payment amounts.

The MMA requires that competitive bidding programs be established and implemented in areas throughout the United States but provides the Secretary with the authority to phase in competitive bidding programs. Competition under the program would be phased in beginning in 2007 in 10 of the largest metropolitan statistical areas (MSAs), in 80 of the largest MSAs in 2009, and in other areas after 2009. Areas that may be exempt from competitive acquisition of DMEPOS include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service. The Secretary may also determine which items will be part of the competitive acquisition program, focusing first on the highest cost and volume items and services or those items and services that have the largest savings potential.

The MMA requires suppliers to achieve and maintain compliance with CMS DMEPOS quality standards in order to submit a bid and be awarded a contract to become a contract supplier for certain DMEPOS in competitive bidding areas. CMS will establish the new DMEPOS quality standards through program instructions and post them on the CMS website.

The MMA also requires the Secretary to establish a Program Advisory and Oversight Committee (PAOC) to provide advice and assistance to the Secretary in implementing the Medicare DMEPOS Competitive Bidding Program. The PAOC members were appointed by the Secretary and represent a broad mix of relevant industry, consumer, and government entities. CMS has presented numerous issues to the PAOC on the development and implementation of this program and utilized their expertise, knowledge and experience to formulate the proposed methodologies.

Proposed Program

Under the proposed rule, suppliers in a competitive bidding area would submit bids for selected items using a request for bid form provided by CMS. The CMS would use this information to select winning suppliers.

Selection of Competitive Bidding Areas

CMS proposed to select the first 10 competitive bidding areas by looking at a combination of factors including the total population in an area, total Medicare spending in the area on DMEPOS items, per beneficiary spending, and the number of suppliers per beneficiary. However, we proposed to exclude the three MSAs with a population of more than 9 million (New York, NY; Los Angeles, CA; and Chicago, IL) from the 2007 implementation to allow us to obtain additional experience with competitive acquisition before implementing the program in the areas with the largest population. The proposed rule provides illustrative data on the top 50 metropolitan statistical areas (MSA) but we

propose to use the most recent data available to actually select the sites under the proposed methodology.

Selection of Competitive Acquisition Items and Services

The MMA gives CMS discretion to phase in items for bidding based on high cost and volume or largest savings potential. CMS proposes to group similar items used for treatment into product categories, such as hospital beds and accessories, so that beneficiaries will be able to receive all related items in the product category from one supplier to minimize disruption of services. CMS proposes to identify the 20 top product categories in terms of total Medicare spending, from which the items or groups of items for inclusion in the bidding process would be selected for the first phase of the program. The bid items may vary by competitive bidding areas.

Bidding

Under the proposed rule, suppliers in a competitive bidding area would submit bids for product categories and CMS would determine the winning suppliers based on these bids. The rule proposes a specific methodology for determining winning bid amounts based on the total capacity needed to meet Medicare demand for DMEPOS items in the area. The Medicare payment amounts would be the median of the winning suppliers' bids for selected items. Suppliers whose bids are lower than the Medicare payment amount set under the competitive bidding program could offer a rebate to beneficiaries.

Suppliers

Suppliers must have a Medicare supplier billing number to submit claims for Medicare payment. In addition, all suppliers must be accredited by a CMS-approved accreditation organization to ensure they meet applicable quality standards. Failure to meet the standards can result in the revocation or suspension of billing privileges and the inability to participate in the Medicare Competitive Bidding Program.

The proposed rule provides an opportunity for suppliers to develop a network to collectively bid to furnish items included in a product category under the Medicare Competitive Bidding Program. This provision would provide important assistance to small suppliers. We also proposed a grandfather provision to allow suppliers who are not selected to participate in the Medicare Competitive Acquisition Program to continue to serve their existing customers.

Impact on Medicare Beneficiaries

The DMEPOS competitive bidding program would have a significant positive impact on Medicare beneficiaries by reducing their out-of-pocket costs. Beneficiary co-payments would be reduced due to lower Medicare DMEPOS prices set through competition. Additionally, beneficiaries may receive rebate offers from the selected contracted suppliers. Because contracted suppliers would be accredited as meeting quality standards, beneficiaries would be assured access to quality medical equipment and DMEPOS supplier services.

Tips for the Public

The proposed rule seeks public comment on a number of key elements of the DMEPOS Competitive Bidding Program. Key elements include:

- The proposed methodology for selecting the ten MSAs for 2007;
- Alternatives to defining Competitive Bidding Areas;
- The proposed methodologies for determining whether an area within an urban area that has a low population density is not competitive;
- Standards for exempting particular rural areas from competitive bidding;
- Methodologies for setting the single payment amount;
- The proposed approach for calculating market demand and estimating supplier capacity;
- Best method of weighting individual items within a product category to determine the composite bid;
- Financial standards evaluation criteria and required documentation;
- Additional options to ensure that small suppliers have opportunities to be considered for participation in the program;
- A process to determine items and/or HCPCS codes for identifying off-the-shelf (OTS) orthotics subject to competitive bidding;
- The proposed rebate process outlined and how to handle those cases in which the rebates would exceed the co-payment amount.

The proposed rule outlines additional requirements that include: 1) application processes to become a CMS approved accreditation organization for the purpose of applying CMS new quality standards for all DMEPOS suppliers; 2) a new fee schedule for home dialysis supplies and equipment that are still paid on a reasonable charge basis; 3) clarification of Medicare policy on the scope of the statutory eyeglass coverage exclusion; and 4) implementation of a revised methodology for calculating fee schedule amounts for new DMEPOS items.

The proposed rule is on display today at the Office of the Federal Register and will be published in the May 1, 2006, Federal Register. Public comments will be accepted until June 30, 2006, and a final rule will be published later this year.

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CMS asks that you share this information with all of your association members and State and local chapters. Thanks!

Countdown Begins - Get Your NPI!

There is less than one year left; don't risk disruption to your cash flow - get your NPI now!

National Provider Identifiers (NPIs) will be required on electronic claims sent on and after May 23, 2007. Every health care provider should obtain an NPI!

Getting your NPI is the first step in the process of meeting the compliance date. Once you have your NPI, you may need to modify your existing business processes to accommodate use of the NPI. You will also need to share your NPI with other health care providers with whom you do business.

Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

Please click here to see the press release:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1870>

I hope everyone enjoys a wonderful Memorial Day weekend!

Valerie

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The Medicare Part B Drug CAP Website's Information for Physicians page
<http://www.cms.hhs.gov/CompetitiveAcquisforBios/02infophys.asp#TopOfPage>

has been updated with the following:

- An audio recording of the CAP Ask the Contractor Teleconference conducted on May 11, 2006 is available in the Downloads section. The teleconference focused on CAP physician election.
- Links to Carrier addresses are available in the Downloads section. Physicians should use these addresses for returning signed and completed Physician Election Forms to their respective local carriers. Please remember that forms must be returned by mail and postmarked on or before June 2, 2006

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Are you receiving an Electronic Remittance Advice (ERA)? Have you tried Medicare Remit Easy Print (MREP) software?

As of June 1, 2006, if you have been receiving **both** an Electronic Remittance Advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a Standard Paper Remittance (SPR) from your carrier/DMERC for 45 days or more, **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. Check out Special Edition MLN Matters article SE0627 which outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC. The article is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> on the CMS website.

For more information about Medicare Remit Easy Print (MREP) software or about receiving a HIPAA-compliant ERA, please contact your Medicare carrier or DMERC, or go to their website. Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf> on the CMS website.

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May 30, 2006

Hello everyone--I hope you enjoyed a wonderful Memorial Day weekend! With the shortened work week upon us, however, it's time to turn our thoughts to the Medicare-covered preventive services that are so valuable to your patients' long-term health. I have selected you as the group of Provider Partners whose association members are most likely to be in a position to provide these services to Medicare beneficiaries. As such, I'm sending you my sincerest plea that you help us spread the message about the availability of Medicare coverage for these preventive services.

Since the January 1, 2005 effective date for the most recently added preventive services (including the "Welcome to Medicare" exam, cardiovascular screening, and diabetes screening), CMS has issued six "*MLN Matters*" articles on Medicare Preventive Services. These articles, in themselves, serve as an excellent source of education for your association members, and also provide information on the Medicare Learning Network (MLN) educational products developed to educate your members about these benefits.

I have attached the six articles, along with a PDF document that contains links to all of the MLN Medicare Preventive Services educational products for Medicare FFS providers. I ask that you share this information with your members through whatever means possible, including electronic bulletins, in-house and outside publications, professional meetings, and association conferences. Your help in getting this information to the grassroots level is critical and invaluable.

If you have any questions, please do not hesitate to contact me either by e-mail or by telephone at (410) 786-6690. Thank you so much for your willingness to help CMS with this most worthwhile effort.

With best regards ~ Valerie



MM3411.pdf (276 KB)



MM3638.pdf (365 KB)



MM3637.pdf (294 KB)



MM3677.pdf (291 KB)



SE0556.pdf (253 KB)



SE0630.pdf (88 KB)



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