Provider Partnership Program (PPP) E-mail Notification Archives

February 1, 2008

Your Friday Reading Materials

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

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Happy Friday everyone! I have several items for you this afternoon, including information on:

- **Modifications to HCPCS Code Set**
- **Reminder of NPI Roundtable Conference Call**
- **Medicare Part B Drug Competitive Acquisition Program (CAP) for Physicians Updates**

- **New from the Medicare Learning Network**
- **Revisions to the HH PPS Grouper**
- **February is American Heart Month**
- **Flu Shot Reminder**

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Modifications to HCPCS Code Set

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp . Changes are effective on the date indicated on the update.

As we previously noted, we continue to work to identify and implement payment and coding changes as necessary to ensure more accurate payments under Section 1847A. So that we can implement any necessary changes promptly, we use our internal process for modifying the HCPCS code set and for adjusting the NDC to HCPCS crosswalk.

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CMS to Host National NPI Roundtable on 2/6/2008

CMS will host a national NPI Roundtable on Wednesday, February 6th from 2:30 – 4PM ET. This call will focus on the status of the Medicare implementation and will address

questions from participants regarding the upcoming March 1st implementation. Registration details are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf on the CMS website.

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<u>Medicare Part B Drug CAP Updates</u>

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period for 2008 is Underway!

The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) began on January 15, 2008 and will conclude on February 15, 2008. This additional election period is being conducted to accommodate recent changes in the CAP that make it more flexible for physicians. Changes to the program include:

- CAP drug administration claims may now be filed up to 30 days after administering CAP drugs;
- Participating CAP Physicians may now request to leave the CAP within the first 60 days of election if program participation results in a burden to a practice (ex: difficulty meeting CAP drug ordering or billing requirements);
- After 60 days, a Participating CAP Physician may request to leave the CAP if an unexpected change in circumstance causes CAP participation to become a burden to a practice (ex: a change in patient population or practice personnel).

Effective dates of participation for physicians who elect to join the CAP during this additional election period will be April 1, 2008 to December 31, 2008. This additional election period is for physicians who have not already elected to participate in the CAP for 2008.

NOTE: Once a physician has elected to participate in CAP, he or she must obtain all drugs on the CAP drug list from the Approved CAP Vendor. Approved CAP Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's Approved CAP Vendor.

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

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

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

- **<u>Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.</u>**

- **Forms must be postmarked on or before February 15, 2008.**
- **DO NOT return forms to CMS offices.**

# # # # # #

CAP "Ask the Contractor Teleconference" for New and Prospective CAP Physicians! February 13, 2008 at 2:00PM CST

2008 CAP Additional Election Period: One More "Ask the Contractor Teleconference" for New and Prospective CAP Physicians! February 13, 2008 at 2:00PM CST

The designated carrier for the Competitive Acquisition Program (CAP), Noridian Administrative Services (NAS), will hold one more 2008 Additional Physician Election Period "Ask the Contractor" Teleconference on February 13, 2008 at 2:00PM CST. New CAP Physicians can learn more about aspects of the program such as the CAP billing modifiers and billing for CAP claims. Prospective CAP physicians will have an additional opportunity to learn more about the CAP and how to elect into the program during the 2008 additional physician election period. **The 2008 Additional Physician Election Period for the CAP concludes on February 15, 2008,** so CAP staff will be available to respond to any general or last minute CAP election inquiries during a question and answer session after the presentation.

Call Number: (800) 700-8174
Note: There is no passcode for this call.

A PowerPoint slide presentation to accompany the "Ask-the-Contractor" teleconference will be posted on the NAS website at: https://www.noridianmedicare.com/cap_drug/train/act.html. The slides will be available at least one day prior to the teleconference (Tuesday, February 12).

Physicians can also contact the NAS CAP Vendor Contact Center at (888)671-0536 with question son the CAP election process or for general program inquiries.

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New from the Medicare Learning Network!

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the

availability of the latest ***Medicare Learning Network*** provider education product entitled, "***Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals."*** *Guided Pathways* has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare Program, as well as for those professionals looking for easy access to the many resources on the CMS website. Using a "road trip" motif, the pathways lead users through nine broad sections of information covering the Medicare Program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items. *Guided Pathways* can be accessed at http://www.cms.hhs.gov/apps/training/guidedpathways/index.html on the CMS website.

Located in the Provider Communications Group within CMS, the Medicare Learning

Network (MLN) is the brand name for official CMS educational products designed to promote national consistency of information developed for Medicare FFS initiatives. Most importantly, it is available to help you! Each quarter the MLN will send updates on the latest products available ~ so be on the lookout! For more information on the Medicare Learning Network, please visit http://www.cms.hhs.gov/MLNGenInfo/ on the CMS website. Questions and requests for additional information can be sent to the MLN Mailbox at ***MLN@cms.hhs.gov*.**

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The ***Home Health Prospective Payment System Fact Sheet***, which provides information about home health coverage and elements of the Home Health Prospective Payment System, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

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Revisions to the HH PPS Grouper

On December 18, 2007, CMS alerted the public that revisions to the HH PPS Grouper were pending. As a follow-up to that announcement, CMS is providing revised final documentation (grouper logic/pseudocode, associated tables, readme file, a summary document of pseudocode and software changes, and test cases) to the Home Health Case Mix Grouper Software and Documentation web page (http://www.cms.hhs.gov/HomeHealthPPS/05_CaseMixGrouperSoftware.asp) for the home health payment regulation effective January 1, 2008. These materials replace those posted on November 16, 2007. The grouper software (.dll) will be forthcoming.

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February is American Heart Month

February is American Heart Month ~ Since 1999, the rate of deaths from coronary heart disease and stroke in American has declined. While much progress has been achieved in reducing the death rate, heart disease and stroke still remain the number 1 and number 3 causes of death in the U.S., and a major cause of disability and reduced quality of life. Found more often among people aged 65 or older, heart disease is largely preventable. The Centers for Medicare & Medicaid Services (CMS) is taking this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests. This screening can help beneficiaries learn if they have an increased risk of heart disease and stroke.

Medicare provides coverage of the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke:

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

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit).

Spread the Word

CMS needs your help getting the word out about the cardiovascular screening benefit covered by Medicare. Talk with your patients about their risk factors for cardiovascular disease and how they can help lessen their risk through lifestyle modifications such as diet, physical activity, better control of cholesterol, and smoking cessation or if necessary with medication. Encourage your Medicare patients not previously diagnosed with cardiovascular disease to take full advantage of the cardiovascular screening blood tests covered by Medicare. It could save their lives!

For More Information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare.

    - The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
    - Expanded Benefits Brochure ~ This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf* To order copies of the brochure, go to the Medicare Learning Network Product Ordering System located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*
    - The CMS website provides additional information about cardiovascular screening benefit at http://www.cms.hhs.gov/CardiovasDiseaseScreening/

- For information to share with your Medicare patients, visit *http://www.medicare.gov*

- For information about American Heart Month, please visit the American Heart Association's website at http://www.americanheart.org/presenter.jhtml?identifier=1200000 and the Centers for Disease Control and Prevention's website at http://www.cdc.gov/DHDSP/announcements/american_heart_month.htm on the Web.

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Flu Shot Reminder

"It's Not Too Late to Give and Get the Flu Shot!
In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu. Get Vaccinated!**

Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."

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I hope you enjoy a wonderful weekend!

With best regards ~ Valerie

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Visit the Medicare Learning Network ~ it's free!

February 5, 2008

NPI Reminders: March 1st is a Critical Date & NPI Roundtable Registration Closes Today!

The NPI is here. The NPI is now. Are you using it?

ATTENTION: Fee-For-Service (FFS) Medicare Physicians, Non-Physician Practitioners & Other Suppliers

Effective March 1, 2008, when required for Medicare claim submission, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.
Visit the CMS NPI web page at
http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp for more details.

Registration Closes Today for CMS National NPI Roundtable on 2/6/2008
CMS will host a national NPI Roundtable on Wednesday, February 6th from 2:30 – 4PM ET. This call will focus on the status of the Medicare implementation of the NPI, and will address questions from participants regarding the Medicare policy affecting Part B claims, which becomes effective March 1st. Registration details are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf on the CMS website.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

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February 5, 2008 cont'd

CMS RELEASES SOLICITATIONS FOR QUALITY IMPROVEMENT ORGANIZATIONS' 9TH STATEMENT OF WORK

CMS RELEASES SOLICITATIONS FOR QUALITY IMPROVEMENT ORGANIZATIONS' 9TH STATEMENT OF WORK

Goal of Three-year Contract Is to Promote Quality and Safety of Care for Medicare Beneficiaries and Improve CMS Management of QIOs

On January 22, 2008, the Centers for Medicare & Medicaid Services (CMS) released the 9th Statement of Work (SOW) for Medicare's 53 Quality Improvement Organizations (QIOs). The 9th SOW is focused on improving the quality and safety of services for beneficiaries and provides CMS additional tools to link the work completed by the QIOs to measurable outcomes that are reviewed and measured during the entire length of the three-year contract.

Responding to concerns raised by the Institute of Medicine (IOM), the Government Accountability Office (GAO) and Congress, and in an effort to improve Agency oversight of the QIOs, CMS is focusing additional efforts and resources to ensure that the QIOs provide Medicare beneficiaries with the highest value in their efforts to improve the quality of care among health care providers.

As part of the contract requirements, QIOs will focus their improvement efforts on Protecting Beneficiaries, Care Transitions, Patient Safety and Prevention. Each program has measurable criteria, close monitoring and performance improvement plans to gauge each QIOs performance under the contract.

QIOs will be required to work with local nursing homes and hospitals to help them improve specific quality measurements – 85 percent of those facilities will be identified by CMS and the remaining 15 percent will be selected by the QIOs. CMS selected the facilities that are targeted for improvement during the QIO 9th SOW by reviewing the

recent publicly reported Quality Measure results, which are found on the "Hospital Compare" and "Nursing Home Compare" websites at www.medicare.gov. It is possible that your facility was selected as one of those targeted for help with quality improvement by your state's QIO.

To see if your facility is one of the thousands the QIO program is targeting for improvement, and to find more information about the 9th SOW), please visit www.cms.hhs.gov/QualityImprovementOrgs.

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February 8, 2008

Your Friday Reading Materials--Early Edition

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

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Good Friday morning everyone—I hope you've had a good week! I have several items for you today, including information on:

- **Proposed Coverage by Medicare with Evidence Development for Artificial Heart Devices**
- **Medicare Part B Drug Competitive Acquisition Program (CAP) for Physicians Updates**

- **New from the Medicare Learning Network**
- **Flu Shot Reminder**

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MEDICARE PROPOSES COVERAGE WITH EVIDENCE DEVELOPMENT FOR ARTIFICIAL HEART DEVICES

The Centers for Medicare & Medicaid Services (CMS) proposed coverage with evidence development of artificial heart devices. CMS proposes to cover artificial heart devices in

Medicare beneficiaries who are enrolled in Food and Drug Administration (FDA)-approved studies.

"Our proposal relaxes a long-standing non-coverage policy, gives access to our beneficiaries and promotes evidence development through FDA approved studies of this advanced technology," said CMS Acting Administrator Kerry Weems.

To view the entire Press Release: http://www.cms.hhs.gov/apps/media/press_releases.asp

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Medicare Part B Drug CAP Updates

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period for 2008 is Underway!

The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

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The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site:
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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

- **Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.**
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2008 CAP One More "Ask the Contractor Teleconference" for New and Prospective CAP Physicians! February 13, 2008 at 2:00PM CST

The designated carrier for the Competitive Acquisition Program (CAP), Noridian Administrative Services (NAS), will hold one more 2008 Additional Physician Election Period "Ask the Contractor" Teleconference on February 13, 2008 at 2:00PM CST. New CAP Physicians can learn more about aspects of the program such as the CAP billing modifiers and billing for CAP claims. Prospective CAP physicians will have an additional opportunity to learn more about the CAP and how to elect into the program during the 2008 additional physician election period. **The 2008 Additional Physician Election Period for the CAP concludes on February 15, 2008,** so CAP staff will be available to respond to any general or last minute CAP election inquiries during a question and answer session after the presentation.

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Note: There is no passcode for this call

A PowerPoint slide presentation to accompany the "Ask-the-Contractor" teleconference will be posted on the NAS website at: https://www.noridianmedicare.com/cap_drug/train/act.html. The slides will be available at least one day prior to the teleconference (Tuesday, February 12).

Physicians can also contact the NAS CAP Vendor Contact Center at (888)671-0536 with question son the CAP election process or for general program inquiries.

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New from the Medicare Learning Network!

New Medicare Learning Network (MLN) Products are now available on the topic of *Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).*

As we have previously mentioned, CMS will soon be offering the Provider Enrollment, Chain and Ownership System (PECOS) and Provider Statistical and Reimbursement Report (PS&R) online. These new online enterprise applications will allow Medicare fee-for-service providers to access, update, and submit enrollment and cost report information over the Internet. Providers and/or appropriate staff must register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). CMS urges FFS providers

to read the series of ***MLN Matters*** articles on this subject and act now. They can be accessed at the following urls:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf

There is another product available on the Medicare Learning Network website that contains **Steps to Accessing CMS Enterprise Applications for Provider Organizations**. The fact sheet/chart can be accessed at the following url: *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*

# # # # #

Newly Updated 2008 MLN Products Catalog! The ***MLN Products Catalog*** is an interactive downloadable document that lists all Medicare Learning Network products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. When selected, all product titles and the word "download" will link you directly to the online version of the product. If you select the word "hard copy" you will automatically link you to the MLN Product Ordering page www.cms.hhs.gov/MLNproducts . To access the catalog, click on the link "MLN Product Catalog" from the MLN Products page at www.cms.hhs.gov/MLNProducts .

# # # # #

Below are a few recently-posted MLN Matters Articles that I thought might be of particular interest to you:

MM5944 – EMERGENCY -- Legislative Change Affecting the 2008 Medicare Physician Fee Schedule (MPFS), and Extension of the 2008 Participation Open Enrollment Period
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5944.pdf

MM5895 – Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5895.pdf

MM5896 – Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5896.pdf

MM5856 – Revision to Instructions Relating to Compliance Standards for Independent Diagnostic Testing Facilities (IDTFs)
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5856.pdf

MM5858 – Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 Claims after NPI Required Date
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5858.pdf

MM5877 – Correction to Low Utilization Payment Adjustment Add-on Payments under the Refined Home Health Prospective Payment System (HH PPS)
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5877.pdf

MM5878 – Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5878.pdf

MM5885 – Additional Payable Healthcare Common Procedure Coding System (HCPCS) "C" Drug Codes in Ambulatory Surgical Centers (ASCs)
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5885.pdf

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Flu Shot Reminder

"It's Not Too Late to Give and Get the Flu Shot!
In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu. Get Vaccinated!**

Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."

* *

You might receive additional items from me today, but just in case let me wish you a very happy weekend!
With best regards ~ Valerie

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Visit the Medicare Learning Network ~ it's free!

February 13, 2008

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period for 2008 is Underway!

Furthermore, please note that CAP drug claims paid after April 1, 2007 are subject to the provisions of Section 108 of the Medicare Improvements and Extension Act of 2006, which amended Section 1847b(a)(3) of the Social Security Act. These provisions and payment of the Medicare and Beneficiary cost sharing components of CAP claims under the methodology effective April 1, 2007 are described in the November 27, 2007 Federal Register on pages 66260-5 (70FR66260-5).

Information on CAP Physician Participation and Drug Claims
Additional information about CAP physicians and CAP drug claims was posted in the Downloads section of the CAP Information for Bidders 2009-2011 web page in January 2008. The files are under the link titled "Vendor Bidding 2009-2011 Addendum."

Since the bidding materials were released, the 2008 CAP physician election numbers have increased to approximately 2800 physicians with January 1, 2008 effective dates. This compares favorably with the number of physicians who had elected to participate at this point in 2007. Please note that the updated 2008 figure still does not include physicians who have elected to participate during the additional election period that is currently under way.

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February 14, 2008

NPI: NPPES Info for Organization Providers, Importance of "Complete" Medicare Enrollment Applications & a New MLN Matters Article

The NPI is here. The NPI is now. Are you using it?

Important National Plan and Provider Enumeration System (NPPES) Information for Organization Providers

When organization health care providers apply for NPIs, it is important that they enter their correct legal business name and Employer Identification Number (EIN).
NPPES will be establishing a verification process with the Internal Revenue Service (IRS) to verify the legal business name and the associated EIN submitted on the NPPES applications and updates. Providers will be notified as CMS develops and implements this process. In the meantime, CMS encourages providers to be proactive and verify that this information is correct in order to avoid any potential issues in the future.

Important Information for Medicare Providers

Importance of "Complete" Medicare Provider/Supplier Enrollment Applications

Correcting your 855 enrollment form can be critical to assuring your claims are processed. We are urging providers to avoid delays in 855 processing that are caused by missing or incomplete information.

CMS has instructed its Medicare Fee-For-Service (FFS) contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the electronic funds transfer authorization agreement (CMS-588) and licensing information, within prescribed processing timeframes. Incomplete or incorrect application information will result in an extension of these processing times for as long as it takes to obtain the correct information from the provider. This wastes precious time, especially for those seeking to rectify NPI/legacy conflicts and poses unnecessary work for both the contractor and the provider.

For an enrollment application to be considered complete:

1. All applicable sections of the CMS-855 and fields, including check boxes, within a section must be filled-out at the time of filing,
2. The application must contain an original signature (blue ink is preferred) and date of signature (blue ink is preferred), and
3. The application must be accompanied by all supporting documentation listed in section 17 of the enrollment application.

Make Sure you Understand the Key Dates: New MLN Matters Article Now Available

The latest NPI-related MLN Matters Article is now available and illustrates information, in chart form, regarding the difference between the March 1st and May 23rd FFS Medicare NPI implementation dates. Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0802.pdf to view this article.

REMINDER for FFS Medicare Physicians, Non-Physician Practitioners & Other Suppliers

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.
Visit the CMS NPI web page at
http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp for more details.

TEST NPI-only NOW: If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no

Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

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Visit the Medicare Learning Network ~ it's free!

February 21, 2008

Your Thursday Reading Materials

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

****

Good Thursday everyone! I'll be out of the office tomorrow so here are your "Friday" reading materials a day early, including information on:

- **Transitional Care Coordination Tools for Home Health Providers**
- **Fully Bundled Medicare Payment System for ESRD**

- **Electronic Health Record Demonstration Project**

- **New from the Medicare Learning Network**
- **DMEPOS Accreditation Quality Standards**
- **Flu Shot Reminder**

* *

<u>Transitional Care Coordination Tools for Home Health Providers</u>

The Centers for Medicare & Medicaid Services (CMS) would like to remind Home Health providers that the Home Health Quality Improvement Organization Support Center (HH QIOSC) has published their final package of best practice intervention tools on the important topic of Transitional Care Coordination. Best practice intervention packages are free and were provided monthly, they include educational tools and resources, guidelines, success stories, and best practice education to assist agencies in reducing avoidable hospitalizations.

The HHQI National Campaign 2007 sought to unite the home care community under the shared vision of reducing avoidable hospitalizations to improve patient quality of care. The HHQI National Campaign utilized a 12-month multi-disciplinary approach to quality improvement that included key home health, hospital, and physician stakeholders. During the campaign, home health agency recruitment and communication occurred locally through state and national home health associations and Quality Improvement Organizations (QIOs). As of February 1, approximately 5,590 home health agencies have registered to participate.

CMS, the Office of Clinical Standards and Quality (OCSQ) would like to acknowledge The Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization (QIO) for Pennsylvania who served as the HH QIOSC for the **wonderful job** they have done in creating these packages for the Home Health Community.

The campaign resources will remain available on the Home Health Quality Improvement (HHQI) web site at www.homehealthquality.org on the internet. In addition, campaign resources are available on Medicare Quality Improvement Community web site at www.medqic.org on the internet.

On the HHQI web site, there is a link for all available free continuing educational units (CNEs) for RNs and for certificates of participation for therapists. See the Continuing Education Frequently Asked Questions (FAQ) section.

Important note: **All continuing education will end on February 28, 2008.**

Thank you for your commitment to quality.

* *

CMS REPORTS TO CONGRESS ON A FULLY BUNDLED MEDICARE PAYMENT SYSTEM FOR ESRD

NEW SYSTEM WOULD ENCOURAGE MORE EFFICIENT, HIGHER QUALITY CARE

Improvements in how Medicare pays kidney dialysis centers could more efficiently deliver services to Medicare beneficiaries with end stage renal disease (ESRD), according to a report to Congress by the Centers for Medicare & Medicaid Services (CMS).

"The analysis lays a solid foundation to implement a more accurate payment system, which would benefit these patients," said CMS Acting Administrator Kerry Weems. "We are currently 60 percent of the way to a proven prospective payment system for ESRD."

To view the entire press release: http://www.cms.hhs.gov/apps/media/press_releases.asp

The full Report to Congress can be viewed on the CMS Web site at: http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/ESRDReportToCongress.pdf

* *

HHS Secretary Invites Communities to Apply for An Innovative Electronic Health Record Demonstration Project
Use of EHRs Can Improve the Quality of Health Care and Reduce Errors

Health and Human Services (HHS) Secretary Michael Leavitt called on community leaders across the country to collaborate and apply for a new demonstration project that provides Medicare incentive payments to physicians for the use of certified electronic health records to improve patient care. The project, which will be open to small- and medium-sized primary-care physician practices, is expected to reduce medical errors and improve the quality of care for an estimated 3.6 million Americans.

This initiative is also part of HHS' bold vision for health care reform built on the four cornerstones of value-driven health care, and a major step toward the President's goal of most Americans having access to a secure, interoperable electronic health record by 2014.

"Communities have a tremendous opportunity to help transform health care delivery starting at the local level," Secretary Leavitt said. "Broad adoption of interoperable electronic health records has the potential not only to improve the quality of care provided, but also to change the way medicine is practiced and delivered."

Over a five-year period, financial incentives will be provided to as many as 1,200 physician practices that use certified electronic health records to improve quality as measured by their performance on specific clinical quality measures. In addition to the incentive payments, bonus payments may be awarded based on a standardized survey measuring the number of EHR functionalities a physician group has incorporated into its practice. Total payments under the demonstration for all five years may be up to $58,000 per physician or $290,000 per practice. On average, it is expected that approximately $3.5 million in incentive payments will be made to participating physician practices in each of the 12 sites under this demonstration.

"By implementing this demonstration project in a dozen health markets across the country, we'll help move this nation toward a system that delivers better quality health care at lower cost for more Americans," Kerry Weems, Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) said.

The application period is open now through early May for communities interested in becoming one of the pilot program's 12 sites. CMS expects that the demonstration will start with four communities in 2008, with the remainder beginning in 2009. Once communities have been selected, CMS will begin working with the communities to recruit physician practices for participation in the demonstration.

For more information about the EHR demonstration project, visit http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1204776

* *

New from the Medicare Learning Network!

New MLN Quarterly Journal Ad—Guided Pathways -- This quarter's journal ad features a new product, *Guided Pathways*. *Guided Pathways* has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare Program, as well as for those professionals looking for easy access to the many resources on the CMS website. Using a "road trip" motif, the pathways lead users through nine broad sections of information covering the Medicare Program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items.

Each calendar quarter, the ***Medicare Learning Network*** creates a journal advertisement based on an initiative or new product of particular importance during that time frame. National, state and local associations are encouraged to use this journal ad in their publications and/or newsletters and websites, as appropriate.

The files for this quarter's ad, as well as future ads, can be found at www.cms.hhs.gov/MLNGenInfo on the CMS Website. Once on the page, click on **Quarterly MLN Journal Ad** (zip file) in the Downloads Section

# # # # # #

The following products are now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network:**

- The revised ***Medicare Physician Fee Schedule Fact Sheet*** (January 2008), which provides general information about the Medicare Physician Fee Schedule, can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf .

- The revised ***Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart*** (January 2008), which provides Medicare claims processing information related to SNF spells of illness, can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/SNFSpellIllnesschrt.pdf .

- The ***Hospital Outpatient Prospective Payment System Fact Sheet*** (revised January 2008), which provides general information about the Hospital Outpatient Prospective Payment System, ambulatory payment classifications, and how payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf .

* *

DMEPOS Accreditation Quality Standards

The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Accreditation Quality Standards have been posted for a 30-day public comment period **only on the underlined/highlighted portions** of the document. Comments must be received electronically or by mail no later than 5:00 P.M. E.S.T., on **Tuesday, March 18, 2008**. The guidelines on how to submit your comments are located on the following web page: http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp.

* *

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot!

In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu. Get Vaccinated!**

Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."

* *

I hope everyone has a great weekend!

With best regards ~ Valerie

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Visit the Medicare Learning Network ~ it's free!

February 21, 2008 cont'd

Important NPI Reminders for FFS Medicare Providers

The NPI is here. The NPI is now. Are you using it?

ATTENTION: Fee-For-Service (FFS) Medicare Physicians, Non-Physician Practitioners & Other Suppliers

Reminder - Effective March 1, 2008, when required for Medicare claim submission, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.

Visit the CMS NPI web page at
http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp for more details.

TEST NPI-only NOW: If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

Getting an NPI is free - not having one can be costly.

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Visit the Medicare Learning Network ~ it's free!

February 29, 2008

Your Friday Reading Materials

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

****

Happy Friday everyone—I hope you've had a good week! I have several items for you today, including information on:

- **Electronic Health Record Demonstration Project**
- **Quality Measure Suggestions for 2009 Physician Quality Reporting Initiative (PQRI)**
- **Reposting of Modifications to the HCPCS Code Set**
- **Inpatient Rehabilitation Facility PPS Information**
- **CMS Identifies $371.5 Million in Improper Medicare Payments in Three States**
- **Follow-Up Information to the February 20th Home Health, Hospice & DME Open Door Forum**
- **Medicare Remit Easy Print Software**

- **New from the Medicare Learning Network**
- **A Health Advisory from the Centers for Disease Control and Prevention**
- **Flu Shot Reminder**

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HHS Secretary Invites Communities to Apply for An Innovative Electronic Health Record Demonstration Project Use of EHRs Can Improve the Quality of Health Care and Reduce Errors

Health and Human Services Secretary Mike Leavitt recently called on community leaders across the country to apply for a new demonstration project that provides Medicare incentive payments to physicians for the use of certified electronic health records (EHRs) to improve patient care. The project, which will be open to small- and medium-sized primary care physician practices, is expected to reduce medical errors and improve the quality of care for an estimated 3.6 million Americans.

"Communities have a tremendous opportunity to help transform health care delivery from the local level on up," Secretary Leavitt said. "Broad adoption of interoperable electronic health records has the potential not only to improve the quality of care provided, but also to change the way medicine is practiced and delivered."

"By implementing this demonstration project in a dozen health markets across the country, we'll help move this nation toward a system that delivers better quality health care at lower cost for more Americans," Kerry Weems, acting administrator of the Centers for Medicare & Medicaid Services (CMS) said.

In a series of meetings with health care providers, health plan and medical association officials, patients, mayors, business leaders, and other stakeholders, Secretary Leavitt,

Deputy Secretary Tevi Troy, and Acting Administrator Weems are urging community leaders to convene stakeholders in their communities to aid in this important drive to bring health care up to 21st century standards. Over a five-year period, financial incentives will be provided to as many as 1,200 physician practices that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. In addition to the incentive payments, bonus payments may be awarded based on a standardized survey measuring the number of EHR functionalities a physician group has incorporated into its practice. Total payments under the demonstration for all five years may be up to $58,000 per physician or $290,000 per practice.

The application period is open now through mid May for communities interested in becoming one of the 12 sites. CMS expects that the demonstration will start with four communities in 2008, with the remainder beginning in 2009. Once communities have been selected, CMS will begin working with the communities to recruit physician practices for participation in the demonstration. Recruitment for the project will focus on locations where the demonstration may enhance existing or planned private sector projects related to health information technology and quality reporting initiatives. "We are looking for communities which have strong ties to primary care physicians and are willing to assist CMS in education activities and the recruitment of physician practices for the demonstration," Weems said.

Eligible communities will include those that:

- Demonstrate active community collaboration with a broad group of stakeholders, including providers and medical professional groups, consumers, health plans, and employers;
- Show private-sector support, with likely probability that similar programs will be implemented among employers or health plans in the region;
- Are geographically large enough to recruit a sufficient number of small- to medium-sized primary-care physician practices, of which 100 will be eligible for incentives and 100 will be control sites; and
- Are not already part of an existing CMS demonstration similar to the EHR project.

The EHR demonstration project is a major step toward the President's goal of most Americans having access to a secure, interoperable electronic health record by 2014. For more information about the EHR demonstration project, visit http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/2008_Electronic_Health_Records_Demonstration.pdf.

This initiative is also part of HHS' bold vision for health care reform built on the four cornerstones of value-driven health care. These include: adopting interoperable health information technology; measuring and publishing quality information to enable consumers to make better decisions about their providers and treatment options; measuring and publishing price information to give consumers information they need to make decisions on purchasing health care; and promoting incentives for high-quality, efficient delivery of care. To learn more about *Connecting to Better Health Care*, please visit www.hhs.gov/secretary/connecthealthcare.

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CMS Requests Quality Measure Suggestions for 2009 Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) is now accepting quality measure suggestions for consideration for possible inclusion in the proposed set of quality measures to be published in the 2009 Medicare Physician Fee Schedule (MPFS) Proposed Rule for the Physician Quality Reporting Initiative (PQRI). For details, visit http://www.cms.hhs.gov/pqri and select the Measures/Codes tab on the left side of the page. Next, scroll down to the Downloads section and select "Notice of 2009 Measure Suggestions."

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Reposting of Modifications to the HCPCS Code Set

The Centers for Medicare & Medicaid Services has reposted the recent scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set to incorporate new changes. The revised update has been posted to the HCPCS website at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

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Inpatient Rehabilitation Facility PPS Information

Effective April 1, 2008: Section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173) amended Section 1886(j)(3)(C) of the Social Security Act to apply a zero percent increase factor for part of fiscal year (FY) 2008 and all of FY 2009. This zero percent increase factor affects the IRF Federal prospective payment rates for discharges occurring on or after April 1, 2008 and on or before September 30, 2008. For additional information, visit http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp .

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CMS Identifies $371.5 Million in Improper Medicare Payments in Three States

The Centers for Medicare & Medicaid Services (CMS) recently announced that $371.5 million in improper Medicare payments has been collected from or repaid to health care providers and suppliers as part of a demonstration program using recovery audit contractors (RACs) in California, Florida and New York in 2007. Nearly $440 million has been collected since the program began in 2005.

"We need to ensure accurate payments for services to Medicare beneficiaries and by taking this important step, people with Medicare can be assured they are being charged correctly for their share of their health care services," Acting CMS Administrator Kerry Weems said. "The RAC demonstration program has proven to be successful in returning overpayments to the Trust Fund and identifying ways to prevent future improper payments. We will use the lessons we learned from the demonstration program to help us implement the national RAC program next year."

To view the entire Press Release: http://www.cms.hhs.gov/apps/media/press_releases.asp

For more information on the RAC program and to view the FY 2007 Status Document, visit: http://www.cms.hhs.gov/RAC

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Follow-Up Information to the February 20th Home Health, Hospice & DME Open Door Forum (ODF)

For those of you who participated in the February 20th Home Health, Hospice & DME ODF, CMS has provided follow-up information to two (2) outstanding issues:

(1) Follow-up to the discussion regarding resumption of care (ROC) and MO826 number of therapy visits:

Since the NA response actually reads "NA Not Applicable: No case mix group defined by this assessment," it would be an acceptable response for a Medicare patient when the assessment will not be used to define a case mix (as in most ROC situations). Because the ROC may act as a recert, which in some cases will be used to define a case mix, at times the M0826 response will require a projected number of visits for the upcoming episode. Vendors will need to determine how to accommodate either scenario. In addition, the recent Q&A listed below may be helpful. This response will be posted publicly in the next quarterly CMS OCCB Q&A release (due in April).

Question: When completing a ROC, do the clinicians mark the number of PT visits in M0826 that was originally on the SOC or do they mark how many PT visits they feel are left?

CMS Response: M0826 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4) data from M0826 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0826 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination and in cases where the data is not need for payment, response NA - Not Applicable: No case mix group defined by this assessment could be reported on M0826. Alternatively, providers may choose to report the total of therapy visits that have been provided during

the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses. While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported.

(2) Follow-up to the discussion related to the wound coding question:

OASIS items have specific instructions from CMS. Further clarification will be obtained by the WOCN**.** The definitions and response-specific instructions for each OASIS item are provided within the "OASIS Implementation Manual".
A Chapter 8 Appendix D is in CMS Clearance. Appendix D will contain HHA diagnosis coding guidelines.

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Medicare Remit Easy Print (MREP) Software

Medicare Fee-for-Service Professional Providers and Suppliers: Are you using Medicare Remit Easy Print (MREP) software to view your remittances?

Check out the benefits of MREP software, such as the reporting features, the search function, and the cost. (It's FREE!). No changes were made to the software in January, so Version 2.3 is still available for download. You can access this version of MREP at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website**.**

Note: The latest Codes.ini file is now available. This file is necessary when the MREP software is distributed.

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New from the Medicare Learning Network

The *Ambulance Fee Schedule Fact Sheet*, which provides general information about the Ambulance Fee Schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf .

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This is an official

CDC Health Advisory

Distributed via Health Alert Network
February 26, 2008, 20:15 EST (08:15 PM EST)
CDCHAN-00270-08-02-26-ADV-N

Important Safety Information -- Revised Directions for Using Rabies Immune Globulin (Human), HyperRAB™ S/D in Fixed Needle 2 mL Pre-filled Syringe

The Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) have been notified by Talecris Biotherapeutics, Inc. that its Rabies Immune Globulin (Human), HyperRAB™ S/D in fixed needle 2 mL pre-filled syringe does not address all dosing situations. Specifically, the fixed needle (22 gauge, 1.25 inch) and the absence of graduations on the 2 mL pre-filled syringe do not permit administration of the recommended dose of Rabies Immune Globulin (Human), HyperRAB™ S/D in one or more of the following situations:

- A dose < 2 mL is required (e.g. for pediatric use);
- A dose < 2 mL must be injected over multiple sites; or
- An alternate needle (different length or gauge) is required based on the patient (adult or child), wound or site of injection.

Three lots of HyperRAB™ S/D have been manufactured with the 2 mL pre-filled syringe configuration (see Table below):

Lot Number	Expiration Date	Size/Container	NDC Number
26N87R1	Jan-26-2009	2 mL pre-filled syringe	13533-618-03
26N88K1	Jan-26-2009	2 mL pre-filled syringe	13533-618-03
26N9HP1	Feb-18-2010	2 mL pre-filled syringe	13533-618-03

Healthcare providers may continue to administer HyperRAB™ S/D supplied in the 2 mL pre-filled syringe by following the “Revised Directions for Use” that are packaged with these lots. The full “Revised Directions for Use” of these lots is available on-line: http://www.talecris.com/us/documents/FINAL_FDA_Approved_Revised_Directions_for_Syringe_Use__21-FEB-08.pdf. Talecris has discontinued manufacturing the HyperRAB™ S/D fixed needle, 2 mL pre-filled syringe.

For additional information regarding this product, please contact Talecris on-line at www.talecris.com, or call 919-412-1030, or toll free at 1-800-520-2807.

Human rabies PEP (post-exposure prophylaxis) is recommended when potentially infectious material (e.g. saliva) from a rabid animal is introduced via a bite, or comes into direct contact with broken skin or mucous membranes. More detailed information regarding evaluation for and administration of PEP is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/00056176.htm.

For more information about rabies and its prevention, contact your state or local public health official or CDC at 1-800-CDC-INFO or visit www.cdc.gov/rabies.

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February Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot! In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu. Get Vaccinated!**

Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf on the CMS website.

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Well, that's it for now. I hope you enjoy this extra February day and your weekend!

With best regards ~ Valerie

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Visit the Medicare Learning Network ~ it's free!

February 29, 2008 cont'd

NPI March 1st Milestone

The NPI is here. The NPI is now. Are you using it?

Important Information for Medicare FFS Providers

March 1 Milestone

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject!

Background

One of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish unique national identifiers for providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. On March 1, 2008, Medicare claims submitted by physicians and other practitioners, laboratories, ambulance company suppliers, DMEPOS suppliers and others that bill Medicare are required to include the new National Provider Identifier (NPI).

Providers must use this information when they submit their claims to Medicare carriers, A/B Medicare Administrative Carriers (MACs), and DME MACs when they use certain electronic and paper Medicare claims (specifically the X12N 837P electronic claim and the CMS-1500 paper claims).

Hospitals, skilled nursing facilities, home health care agencies and other such institutional providers were required to begin using their NPI beginning on January 1, 2008

The deadlines for submitting Medicare claims using the NPI are necessary to help the Centers for Medicare & Medicaid Services (CMS), the Medicare contractors and health care providers prepare for the final May 23, 2008 deadline for full NPI compliance. While the final NPI Rule required compliance on May 23, 2007, CMS stated in the NPI National Contingency Guidance that it will not take enforcement action against covered entities that deploy contingency plans through May 23, 2008, provided that conditions in the Guidance were met.

CMS is anticipating that some providers will experience some problems with claims submitted after March 1 – problems could arise in the following situations:

- The provider does not have an NPI
- The provider does not submit their NPI on their claim
- The provider has already received an NPI, but the NPI is not consistent with the provider's enrollment information received by the contractor.

Providers whose claims are rejected and returned to them should immediately contact their contractor before resubmitting that claim or submitting new claims for services provided to Medicare beneficiaries. Contact information for the Medicare contractors can be found at **www.cms.hhs.gov/MLNGenInfo/** under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Current Status

Physicians, non-physician practitioners, labs, ambulance company suppliers, DME suppliers, and others who traditionally bill carriers and DME MACs (2/22/08)

- 91.3% of Medicare carrier claims and 88.5% of DME MAC claims are being submitted with an NPI or NPI/legacy pair in the primary provider identifier fields (these numbers are consistent with institutional provider NPI use before the January 1 change).

- For claims submitted with an NPI, the current reject rate for carrier and DME MAC claims ranges from 1-12%, depending on the carrier. CMS has received very few complaints from providers.

Institutional Providers (January 1, 2008, deadline)

- In mid-January, the NPI submission rate jumped to 99% - compared to 90% in December.

- Currently, the submission rate is over 99.9%. Less than 0.1% of claims are being rejected for not having an NPI in the appropriate fields.

The March 1, 2008, Deadline

Expectations for March 1:

- A small portion of claims will continue to be submitted without an NPI. These claims will be rejected. Providers have had over two years to acquire and test their NPI.

- Some rejections may occur because a contractor has not completed processing a provider's enrollment application, submitted by the provider to fix inconsistencies between a provider's NPI and Medicare's provider enrollment files.

Medicare Risk Mitigation

CMS and the Medicare contractors are taking aggressive steps to ensure that providers will be paid for treating Medicare beneficiaries after March 1.

Medicare contractors are enhancing their toll-free phone lines by expanding the number of people available to answer calls. Throughout the month of February, CMS has intensified its planning efforts to assist contractors to prepare for the March 1 implementation date. In February 2008, CMS held a training session with contractor call centers and CMS regional office staff to ensure they are able to address provider inquiries on NPI issues.

Daily calls with the carriers, A/B MACs, and DME MACS are scheduled to monitor the status of successful and rejected claims, inquiries, enrollment backlog status, and other relevant information.

Each contractor has created a NPI Coordination Team to quickly identify and resolve claims processing issues related to the submission of the NPI or NPI-Legacy combination, expedite the processing of enrollment applications, and address other issues that may arise.

CMS has implemented temporary measures to allow the Medicare contractors time to address some of the backlog issues, but at some contractors, more work is needed.

Current Claims Process as of March 1

Currently, most Medicare providers (and their claims clearinghouse vendors) are submitting claims that include their new NPI. For those providers who don't have an NPI, they are submitting claims using their legacy provider numbers. When the claim is submitted, Medicare's computer systems will check to confirm that the claim includes an NPI. If there is no NPI, the claim will be rejected and the provider will receive an error message pointing to the lack of an NPI. If the provider has an NPI, the provider should make sure that the number is on the claim and resubmit the claim. If at that point the claim is again rejected, the provider should

immediately contact the Medicare contractor to ensure that all provider records are correct before resubmitting the claim.

Contact information for the Medicare contractors can be found at www.cms.hhs.gov/MLNGenInfo/ under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Medicare contractors expect to be able to handle all incoming calls, but some callers may experience extended hold times. CMS is urging providers to be patient – their issues will be addressed.

The Future – May 23, 2008

With May 23, 2008 less than three months away, CMS and the Medicare health care providers must make sure they are ready for full NPI implementation. Providers must be certain their NPI information and Medicare enrollment information is accurate and up-to-date before that date. Further, if providers' claims are being successfully processed with NPI/legacy pairs (and most are) now is the time for them to begin testing claims using only the NPI. Providers should start with small volumes of these NPI-only claims and gradually increase their submissions. Doing this testing now will allow time for any needed corrections prior to the May 23, 2008, deadline when claims must include the NPI only.

What to do if your 837P and CMS-1500 Claims are Rejected

- Check your record in the National Plan and Provider Enumeration System (NPPES)
    - Validate that the legacy identifier sent on the claim is reported in the provider/supplier's NPI Registry record. If the legacy identifier is not there, instruct the provider/supplier to add it.
    - Validate that the Legal Business Name (if the provider/supplier is an organization) or the Legal Name (if the provider/supplier is an individual or a sole proprietorship) is correct.
    - Validate that the correct Entity type was selected by the provider/supplier when applying for the NPI. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

  (Note: If you enumerated through the EFI alternative, you should use the NPI Registry to check the content of the NPPES file. Make sure to have the Customer Service Representative at your Medicare contractor verify your TIN/EIN as the NPI Registry does not list this information.)
- If these claims are still rejecting, call your Medicare Contractor.
    - Have a copy of the NPPES record in hand. A copy of the NPPES record can be obtained online at https://nppes.cms.hhs.gov . The Employer Identification Number or Social Security Number will not be shown on this print out.
    - Have the claim reject number and message
    - Be prepared to give the following information:
        1. Legal Business Name of the Organization
        2. Contractor Tracking Number (if known)
        3. Approximate date (month/year) when the 855 enrollment application was submitted
        4. Provider/Supplier Tax Identification Number or Social Security Number (SSN)
        5. National Provider Identifier (NPI)
        6. Medicare legacy Identifier
        7. Practice location on claim (i.e. where is the practice located (e.g. 100 Main St. New Orleans, LA)

8. Contact Information where Provider/Supplier can be reached if further discussion is needed

TEST NPI-only NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

Transcript from February 6th Roundtable now Available

The transcript from the February 6th NPI Roundtable on the FFS Medicare Implementation is now available at http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp on the CMS NPI web page.

Need More Information?

Still not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.