Provider Partnership Program (PPP) E-mail Notification Archives

July 1, 2008

The Latest Newsletter from CMS' Office of Research, Demonstrations, and Initiatives

1. *Health Care Financing Review*

Since our last newsletter, ORDI released the Spring 2008 edition of the *Health Care Financing Review*, the agency's journal of information, analysis, and research on a broad range of health care financing and delivery issues. This issue was devoted to general topics, rather than a specific theme. Included are an article on Medicare disease management, an examination of medication patterns for Medicare beneficiaries with skilled nursing facility or long-term-care facility stays, and a report on access and satisfaction among children in Georgia's Medicaid and State Children's Health Insurance programs. Also featured are highlights from the ongoing Medicare Current Beneficiary Survey. Click here to view the Spring edition.

2. Medicare Current Beneficiary Survey (MCBS) – Access to Care 2006

ORDI has released the 2006 MCBS Access to Care data files. The MCBS is a continuous, multi-purpose panel survey consisting of a representative sample of the Medicare population, including both aged and disabled enrollees. The Access to Care files contain a variety of information about Medicare beneficiaries' demographic characteristics, health status and functioning, access to care, insurance coverage, financial resources, and potential family support collected by the MCBS. The 2006 Access to Care files also contain results from new Part D related questions added to the MCBS. In addition, a special new enrollee sample and questionnaire have been added to the MCBS to study the effects of the "Welcome to Medicare" benefit, which was added to the Medicare program on January 1, 2006. These "New Enrollee" versions of the 2006 Access to Care files have been generated separately from the regular files and are available upon request. Additional Access to Care data files are also available for calendar years 1991-1995.

For more information about MCBS, please visit http://www.cms.hhs.gov\mcbs.

3. Medicare Current Beneficiary Survey (MCBS) – Cost and Use 2005

ORDI has released the 2005 MCBS Cost and Use data files. While the MCBS Access to Care file is designed as a quick release file containing information directly reported in the survey, the MCBS Cost and Use data are put through a reconciliation process to compare health care services reported in the survey to CMS's administrative claims data. This process enables ORDI to produce a file with a more complete and accurate picture of both covered and non-covered health services received by Medicare beneficiaries as well

as the amounts paid and sources of payment for these services. Additional MCBS Cost and Use data are available for calendar years 1992- 2004.

For more information about MCBS please visit http://www.cms.hhs.gov\mcbs.

4. Historically Black Colleges and Universities (HBCU) Grant Program

CMS has announced the availability of funds under its grant program to assist Historically Black Colleges and Universities (HBCUs) in conducting health services research. The purpose of the grant program is to support researchers in implementing health services research activities to meet the needs of diverse CMS beneficiary populations. The goals of the grant program are to: 1) encourage HBCU health services researchers to pursue research issues which impact the Medicare, Medicaid, and SCHIP programs, 2) assist CMS in implementing its mission focusing on health care quality and improvement for its beneficiaries, 3) assist HBCU researchers by supporting extramural research in health care capacity development activities for the African American communities, 4) increase the pool of HBCU researchers capable of implementing the research, demonstration, and evaluation activities of CMS, and 5) assist in fostering interuniversity communication and collaboration regarding African American health disparity issues.

A copy of the grant announcement and additional information on the HBCU grant program is available here.

5. Hispanic Health Services Research Grant Program

CMS has announced the availability of funds under its Hispanic Health Services Research Grant Program, to inform researchers of funding opportunities to conduct health services research affecting Hispanic American communities. This announcement seeks competitive applications for small applied research projects that relate to identifying and evaluating solutions for eliminating health disparities among Hispanic Americans. Investigators should be associated with a university, college, community-based health organization, or a professional association that has a health services research component. Researchers are expected to become involved in the design, implementation, and operation of research projects that address health care issues such as financing, delivery, access, quality, and barriers affecting the Hispanic American community. CMS is seeking these types of research projects because of the importance in finding solutions to the many difficult health issues that have a significant impact on the health of Hispanic Americans.

A copy of the grant announcement and additional information on the Hispanic Health Services Research grant program is available here.

6. Current Demonstrations and Research Projects

Acute Care Episode (ACE) Demonstration

The Acute Care Episode (ACE) demonstration will test the use of a bundled payment for both hospital and physician services for a select set of episodes of care to improve the quality of care delivered through Medicare fee-for-service.

The goal of the ACE demonstration is to use a global payment to better align the incentives for both types of providers, leading to better quality and greater efficiency in the care that is delivered. The demonstration will also test the effect that transparent price and quality information has on beneficiary choice and provider referrals for select inpatient care.

More information can be found here.

The Frontier Extended Stay Clinic (FESC) Demonstration

ORDI is initiating a demonstration project that will enhance essential emergency services to residents in the nation's most remote rural areas. The Frontier Extended Stay Clinic (FESC) Demonstration will implement section 434 of the Medicare Modernization Act, allowing remote clinics to provide services to seriously or critically ill or injured patients when weather or other conditions prevent transfer to a hospital. Four of the six approved clinics are in Alaska, with one each in Washington and Montana. The demonstration will provide Medicare reimbursement, whereas currently these clinics are not reimbursed for extended stay services. According to the statute, an FESC must be located in a community which is at least 75 miles away from the nearest acute care hospital or critical access hospital, or which is inaccessible by public road.

Additional information on the demonstration can be found here.

Webinar on Succeeding in Physician Pay for Performance

What it takes for small practices to succeed in pay for performance was the subject of a webinar sponsored by the Robert Wood Johnson Foundation (RWJF) and the Agency for Healthcare Research and Quality (AHRQ) featuring physician leaders participating in CMS's Medicare Care Management Performance Demonstration and Physician Group Practice Demonstration, and RWJF/AHRQ's Rewarding Results pay-for-performance demonstrations. These clinical leaders discussed their organization's experience under the demonstrations and provided guidance, tools, and tips on how to redesign patient care, capture data necessary for reporting quality measures, and use that data at the point of care to transform care for Medicare beneficiaries.

The webinar recording and presentation slides can be accessed here.

Electronic Health Record (EHR) Demonstration Project

More than 30 communities applied for a new demonstration project that will provide Medicare incentive payments to primary care physician practices that use certified electronic health records (EHR) to improve the quality of patient care. The

demonstration will be implemented in two phases. CMS will begin working with the partners in Phase I communities over the coming months to develop site-specific recruitment strategies, and recruitment of physician practices will start in the fall. These activities will begin in 2009 for Phase II sites. The four communities selected for Phase I implementation are Louisiana; Maryland/Washington, D.C.; Pittsburgh, Pennsylvania (and surrounding counties); and South Dakota (and surrounding counties in Iowa, Minnesota, and North Dakota).

The EHR demonstration project is expected to reduce medical errors and improve the quality of care for an estimated 3.6 million Americans. Over a 5-year period, financial incentives will be provided to as many as 1,200 small- to medium-sized physician practices in 12 communities for using certified EHRs to improve quality, as measured by their performance on specific clinical quality measures.

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, click here.

7. New Research Reports

"Evaluation of the Preferred Provider Organization (PPO) Demonstration Final Report"

Beginning January 1, 2003, CMS launched a 5-year PPO demonstration program. The goals of this demonstration were to expand the types of managed care products available to Medicare beneficiaries and test the impact of enhanced payment and risk sharing on the range of options and benefits available to beneficiaries. Research Triangle Inc. (RTI) conducted an evaluation of the demonstration for CMS and the final report is now available. The evaluation shows the demonstration succeeded in one of its major goals: a large number of national and regional companies offered a substantial number of plans in a wide variety of geographic areas. Although many plans were offered, enrollment and market share under the demonstration was modest. PPO enrollees were similar to other Medicare Advantage plan enrollees. They tended to be healthier than the average beneficiary in the traditional Medicare program. The demonstration was a precursor to the local and regional PPOs established by the Medicare Modernization Act of 2003, and many demonstration plans transitioned to Local PPOs in 2006.

The final report can be obtained by contacting the Project Officer, Penny Mohr, at penny.mohr@cms.hhs.gov.

"Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2006, Final Report"

This report evaluates important changes that occurred in the Medicare Advantage program (MA) in 2006. Enrollment in MA plans had declined in the early years of the decade but rebounded in response to the Medicare Modernization Act (MMA) payment increases taking effect in 2004. The MMA also mandated a major new benefit to the basic Medicare benefit package in 2006, the Part D prescription drug benefit. Beginning in 2006, most MA plans were required to offer at least one plan in an area with the standard Part D prescription drug benefit (or an actuarially equivalent benefit). This report addresses the changes to plan availability; plan premiums, benefits, and cost sharing; and enrollment in the MA program. The report is available here

Release of *Older Americans 2008: Key Indicators of Well-Being*

Older Americans 2008, the fourth chartbook prepared by the Federal Interagency Forum on Aging Related Statistics (Aging Forum) since 2000, provides an updated, accessible compendium of indicators, drawn from the most reliable official statistics about the well-being of Americans primarily age 65 and over. The indicators are categorized into five broad areas—population, economics, health status, health risks and behaviors and health care. The 160-page report contains data on 38 key indicators—and a one-time special feature on health literacy.

The Forum—a consortium representing 15 agencies with responsibilities for Federal data collection or aging programs, including CMS—collects, interprets and updates these data and makes them available to government agencies, policymakers, the media and the public.

Older Americans 2008: Key Indicators of Well-Being is available online here and in limited quantities in print. Supporting data for each indicator, including complete tables, PowerPoint slides and source descriptions, are also available here.

Single printed copies of *Older Americans 2008: Key Indicators of Well-Being* are available at no charge through the National Center for Health Statistics while supplies last. Requests may be made by calling 1-866-441-6247 or by sending an e-mail to nchsquery@cdc.gov.

8. June 25 Satellite Broadcast – "Health Implications of Caregiving"

On Wednesday, June 25, from 1:00-2:30 p.m. EST, CMS will be offering a satellite broadcast to provide viewers with information on how caregiving impacts the health and wellbeing of the caregivers themselves. It will provide tips on self-care, approaches taken by several organizations to support family caregivers, and innovative programs that help caregivers take care of their own health. This program is geared towards those in the community who help caregivers identify and utilize resources that help them preserve and improve their own health. There are five ways to connect to this broadcast: steerable satellite dish, webcasting, streaming video, video conferencing, and audio line.

Following the broadcast, starting at 2:30 p.m., there will be a live 30-minute Q&A session (via audio lines only) with the broadcast presenters.

To register and for more information on the broadcast, please click here.

If you have any questions, please email cargivers@cms.hhs.gov.

Previous Listserv newsletters are available under the heading "ORDI Research News Listserv Archive" here.

July 1st Cont'd

CMS Proposes Payment, Policy Changes for Physicians' Services in 2009

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

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Hello everyone! I apologize for the plethora of messages you've already received from me this week but it's been quite busy around here and doesn't show signs of slowing down anytime soon. So please bear with me for a few more messages before the holiday weekend kicks in—thanks!

CMS PROPOSES PAYMENT, POLICY CHANGES FOR PHYSICIANS' SERVICES IN 2009

PROPOSED REGULATION PROMOTES HIGHER QUALITY, EFFICIENT CARE

The Centers for Medicare & Medicaid Services (CMS) recently proposed new efforts to promote access to higher quality and more efficient health care delivered by the nation's physicians to people with Medicare under the 2009 Medicare Physician Fee Schedule (MPFS).

"We are taking a multi-pronged approach to improve how Medicare pays for health care services for our nation's seniors," said CMS acting administrator Kerry Weems. "These efforts are designed to ensure that beneficiaries continue to get the highest quality of health care at the greatest value for beneficiaries and the Medicare program."

CMS will accept comments on the proposed rule until August 29, 2008, and will respond to those comments in a final rule to be issued by November 1, 2008. The revised policies and payment rates will become effective January 1, 2009.

The entire Press Release is attached for your convenience. The CMS Fact Sheet can be accessed at http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3183&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date .

For additional information, see http://www.cms.hhs.gov/center/physician.asp.

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With best regards ~ Valerie

July 1st, Cont'd

The Medicare DMEPOS Competitive Bidding Program is here!

Supplier Directory Locator Tool Now Available!

As of Tuesday, July 1, 2008 the Supplier Directory on http://www.medicare.gov has been updated to reflect the start of the DMEPOS Competitive Bidding program in certain areas of the country.

Users can begin their search on the Supplier Directory by entering their zip code. Product categories in that zip code that are competitive bid are identified, and special messaging will let users know if they have chosen an applicable product in a Competitive Bid Area (CBA) and why that is important to know. Search results for CBAs are organized by city of the zip code that was entered, and then by state. Users can sort by Supplier Name, and whether or not the supplier is participating. The address and phone number of the supplier is available.

Users are encouraged to check the site frequently as CMS will be making regular updates during the start of this program.

Clarification of Common Carrier and Local Storefront Suppliers Under the CMS DMEPOS Competitive Bidding Program

Common carrier, in its basic meaning, includes individuals or companies that transport goods or cargo (e.g., diabetic testing supplies) for compensation. This means that suppliers that pay a common carrier such as the U.S. Postal Service, Federal Express, United Parcel Service, or other shipping or courier service companies to transport

diabetic testing supplies to Medicare beneficiaries' homes must be mail order contract suppliers under the DMEPOS Competitive Bidding Program, regardless of any contract arrangements suppliers may have with common carriers to deliver these items.

Diabetic supplies delivered by a common carrier to a Medicare beneficiary's home in a competitive bidding area must be furnished by a mail order contract supplier in order for Medicare to make payment unless the supplies are delivered by a local storefront using its own vehicles and W2 employees. This local storefront supplier must have its own local storefront that services the competitive bidding area, have its own location-specific National Supplier Clearinghouse (NSC) number for that storefront, bill for the diabetic supplies using that NSC number, and meet all of Medicare's supplier standards. It must also offer beneficiaries the choice of either obtaining the diabetic supplies from the supplier's storefront or having the items home delivered by the local storefront supplier using its own vehicles and W2 employees.

Reminder: Enteral Nutrition is Not a "Grandfathered" Competitively Bid Item

Under the DMEPOS Competitive Bidding Program, enteral nutrition must be furnished by a contract supplier and cannot be provided by a non-contract grandfathered supplier. To ensure that there is no gap in service, this is important information for providers who order enteral nutrition for Medicare beneficiaries who permanently reside in or are visiting a CBA.

National Provider Call for Referral Agents and Non-Contract Suppliers – July 8, 2008

CMS will host a national audio call to address additional questions on the DMEPOS Competitive Bidding Program, which was implemented today, July 1, 2008. The call will be held on July 8, 2008 from 2:30 – 4:00 PM EDT. This call will not address contract supplier issues, but will instead focus on questions from non-contract suppliers and referral agents (Medicare providers who order or refer DMEPOS in the 10 CBAs).

Please note -- Participants will be able to submit questions through the online registration system at the time of sign up for the call. Registration details follow.

Conference call details:

Date:	July 8, 2008
Conference Title:	DMEPOS Competitive Bidding Program
Time:	2:30-4:00 p.m. EDT

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to

receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation. If you cannot attend the call, replay information is available below.

Registration will close at 2:30 p.m. EDT on July 7, 2008, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants need to go to: http://www2.eventsvc.com/palmettogba/070808

2. Fill in all required data.

3. Verify your time zone is displayed correctly the drop down box.

4. Click "Register".

5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who will be unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 4:30 p.m. EDT 7/8/2008 until 11:59 p.m. EDT 7/15/2008. The call in data for the replay is (800) 642-1687 and the passcode is 53825755.

Educational Products: New SNF/NF Specialty Supplier Tip Sheet!

Within the next day, CMS will post a new tip sheet on SNF/NF Specialty Suppliers under the DMEPOS Competitive Bidding Program.

Below is a complete listing of provider Tip Sheets that can be accessed from our dedicated web page:

Tip Sheet for Skilled Nursing Facilities and Nursing Facilities: Specialty Contract Suppliers

Tip Sheet for Referral Agents

Tip Sheet for "Grandfathered" Suppliers

Tip Sheet for Mail-Order Diabetic Testing Suppliers

Tip Sheet for Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers

Tip Sheet for Non-Contract Suppliers

Go to http://**www.cms.hhs.gov/DMEPOSCompetitiveBid** to access all the latest information on the new program. Just click on the "Provider Educational Products and Resources" tab on the left then scroll down to the "Downloads" section for all *MLN Matters* articles, Tip Sheets, and links to beneficiary educational products as well.

July 1st, Cont'd

Claims Paid Under the Medicare Physician Fee Schedule - News from CMS

To the extent possible, the Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other Fee-For-Service (FFS) providers of services paid under the Medicare physician fee schedule, beginning July 1. In this regard, CMS has instructed its contractors to hold these claims for the first 10 business days of July, for dates of service in July. This should have minimum impact on provider cash flow because, under current law, electronic claims are not paid any sooner than 14 days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before June 30 will be processed and paid under normal procedures.

After 10 business days, contractors will begin releasing claims into processing under the fee schedule which implements current law. This, of course, could result in claims being processed with the negative 10.6 percent update. If a new law is enacted which changes the negative 10.6 percent update, retroactive to July 1, CMS is prepared to automatically reprocess most of those claims which have already been processed.

Under the Medicare statute, Medicare pays the lower of submitted charges and the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1-June 30, 2008, fee schedule will be automatically reprocessed if Congress retroactively reinstates the update that was in effect for that time period. Any lesser amount will likely require providers to re-submit a revised claim.

To the extent possible, providers may hold claims in-house until it becomes clearer as to whether new legislation will be enacted or until cash flow becomes problematic. This will reduce the need for providers to reconcile two payments (i.e., the initial claim and the reprocessed claim), and it will simplify provider billings of beneficiary coinsurance and payment calculations for payers which are secondary to Medicare.

In addition, be on the alert for more information about other legislative provisions which may affect Medicare FFS providers.

July 1st, Cont'd

News from CMS: Expiration of Therapy Cap Exceptions

Expiration of Therapy Cap Exceptions

The exceptions to outpatient therapy caps expire on June 30, 2008. Outpatient therapy service providers should not submit claims with the KX modifier for services furnished on or after July 1, 2008. To the extent possible, CMS is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of outpatient physical therapy, occupational therapy and speech-language pathology claims for services furnished by physicians, non-physician practitioners, and therapists paid under the physician fee schedule, beginning July 1.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Therapy cap accruals began on January 1, 2008, and some patients may have reached the annual limits by June 30, 2008.

Providers may access the accrued amount or remaining amount of therapy services from the Medicare beneficiary eligibility inquiry and response transactions. Specifically:

For CWF users, the system returns the "applied" amount. See CR4115 at http://www.cms.hhs.gov/transmittals/downloads//R759CP.pdf

For users of the HETS 270/271, the system returns the "remaining" amount. See the page 18 of the 270/271 user guide at http://www.cms.hhs.gov/HETSHelp/Downloads/HETS%20270-271%20User%20Companion%20Guide.pdf

The Medicare contractors' Interactive Voice Response units (IVR) return either the remaining or applied amounts based upon contractor programming. For those few contractors that do not provide this information on their IVRs, providers can call the contractors' customer service representatives.

For additional information, Providers and Suppliers should also read the Medicare Claims Processing Manual, chapter 5, section 10. 2 at http://www.cms.hhs.gov/manuals/downloads/clm104c05TXT.pdf

Patients Who Have Reached Their Limit(s) on Outpatient Therapy Services:

Note that patients who have reached their limit(s) on outpatient therapy services, other than those who reside in a Medicare-certified part of a skilled nursing facility, may obtain medically necessary therapy services that exceed the caps if the services are furnished and billed by the outpatient department of a hospital. In other settings, outpatient therapy services in excess of the caps are not covered, and the therapy provider may charge for those services. An Advance Beneficiary Notice is recommended, but not required for services that exceed therapy caps. An ABN is available at the following link: http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage (click on ABN-CMS-R-131 Form). In the box titled "Reason Medicare will not pay" the following language is suggested Medicare will not pay more than $1810 for expenses incurred for physical therapy and speech-language pathology services combined or for occupational services in 2008.

Patients may be referred to this website for further information: http://www.medicare.gov/Publications/Pubs/pdf/10988.pdf

CMS will continue to be in communication with you with further information about payment of Medicare physician fee schedule claims. In addition, be on the alert for more information about other legislative provisions which may affect you.

July 2, 2008

News from CMS: Questions and Answers on Announced 10 Day Hold

The Questions and Answers below apply to the recent decision by the Centers for Medicare & Medicare Services to hold claims paid under the Medicare physician fee schedule (MPFS) up to 10 business days that contain July 2008 dates of service.

Q1. Will claims containing services paid under the MPFS be held that contain both June and July dates of service?
A1. Yes, your local contractor will hold the entire claim for 10 business days.

Q2. Will claims be held that contain both services paid under the MPFS and services paid under a separate fee schedule?
A2. Yes, claims that contain both services paid and not paid under the MPFS will be held. For example, a claim with a July date containing an Evaluation and Management code and a drug code would be held.

Q3. Does the holding of claims paid under the MPFS also include anesthesia and purchased diagnostic services?
A3. Yes, contractors will hold all claims with dates of service July 1, 2008, and after that contain services paid under the MPFS, including anesthesia and purchased diagnostic services.

July 3, 2008

Reminder: DMEPOS Competitive Bidding national provider call for referral agents and non contract suppliers - July 8, 2008

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Please note -- Participants will be able to submit questions through the online registration system at the time of sign up for the call. Registration details follow.

Conference call details:

Date: July 8, 2008

Conference Title: DMEPOS Competitive Bidding Program

Time: 2:30-4:00 p.m. EDT

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Registration will close at 2:30 p.m. EDT on July 7, 2008, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

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2. Fill in all required data.

3. Verify your time zone is displayed correctly the drop down box.

4. Click "Register".

5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Note: Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive

the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who will be unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 4:30 p.m. EDT 7/8/2008 until 11:59 p.m. EDT 7/15/2008. The call in data for the replay is (800) 642-1687 and the passcode is 53825755.

July 3rd, Cont'd

CMS Proposes Quality Improvements and Other Changes for OPPS and ASC Services for 2009

CMS PROPOSES QUALITY IMPROVEMENTS AND OTHER CHANGES FOR HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES FOR 2009

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that will update payment rates for calendar year (CY) 2009 and improve quality of services provided in hospital outpatient departments and ambulatory surgical centers (ASCs). The proposed rule builds on efforts across Medicare to transform the program into a prudent purchaser of health care services, paying based on quality of care, not just quantity of services.

The proposed rule will update rates paid under both the Outpatient Prospective Payment System (OPPS) and the ASC Prospective Payment System (ASC PPS), which will be in the second year of a four-year transition that aligns ASC rates with the ambulatory payment classification (APC) groups that are used to pay for services in hospital outpatient departments.

To read the entire CMS Press release issued today click here:
http://www.cms.hhs.gov/apps/media/press_releases.asp\

To read the CMS Fact sheet issued today click here:
http://www.cms.hhs.gov/apps/media/fact_sheets.asp

For more information on the CY 2009 proposals for the OPPS and ASC payment system, please see the CMS Web site at:
OPPS: http://www.cms.hhs.gov/HospitalOutpatientPPS/
ASC payment system: http://www.cms.hhs.gov/ASCPayment/

If you cannot access any of the links in this email, copy and paste the url into your web brower.

July 7, 2008

Your Monday Reading Materials

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

Happy Monday everyone! I hoped you enjoyed your 4th of July holiday. I apologize for the volume of e-mail messages that have been flowing from my office lately but there's been so much happening around here that it's sometimes difficult to consolidate it into one Friday message. At any rate, I'll try to do a better job of coordination but wanted to start your week off with a few items that came in over the holiday, including information on:

Expiration of Moratorium That Allowed Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, the carriers and, more recently, Medicare Administrative Contractors (MAC) have

continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium was established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA). Section 104 of the MMSEA expired on June 30, 2008, thus ending the moratorium. Therefore, independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed**. This prohibition is effective for claims with dates of service on and after July 1, 2008.**

Medicare Part B Drugs and Biologicals Competitive Acquisition Program (CAP) Updates

Medicare Part B Drugs and Biologicals Competitive Acquisition Program (CAP): Post Payment Review and Medical Record Requests

The post-payment review process for the CAP is conducted to verify drug administration for Medicare claims submitted by an Approved CAP Vendor. For this process, a small sample of physician and Vendor claims and other documentation is examined in order to establish that drugs billed by an Approved CAP Vendor were administered and were medically necessary.

To support this review, participating CAP physicians may receive a request for copies of medical records from the CAP designated carrier, Noridian Administrative Services (NAS). Medicare requirements and the CAP Terms of Agreement require participating CAP physicians to submit all information necessary to support the services billed on claims.

Participating CAP physicians must submit medical records to NAS within the requested timeframe. This submission should include the patient's drug administration record and all other records supporting medical necessity for the drug.

If CAP post payment review activity cannot establish that a drug was administered, then the vendor's drug claim will be denied. The associated physician drug administration claim will also be referred to the physician's local carrier for review and recoupment as necessary.

For additional information on the post payment review process, please visit NAS's website at: https://www.noridianmedicare.com/cap_drug/index.html.

Medicare Part B Competitive Acquisition Program (CAP) for Drugs and Biologicals: July 1, 2008 CAP Drug List Update

The list of drugs available under the CAP has been updated and is now available in the 'Downloads' section on the CMS CAP "Information for Physicians" page at: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp.

The following drug has been added to the CAP effective July 1, 2008: Vectibix® panitumumab (J9303). The list of NDCs available under the CAP has also been updated.

New from the Medicare Learning Network

The revised ***Rural Referral Center Fact Sheet*** (April 2008), which provides information about Rural Referral Center program requirements, is now available in print format from the **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."

MLN Matters Article **SE0821** *Reminder - Medicare Provides Coverage of Diabetes Screening Tests http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0821.pdf.* This article reminds health care professionals that Medicare pays for diabetes screening tests for eligible beneficiaries and provides the correct procedure and diagnosis codes and modifier to use when filing claims for this screening service.

CMS PROPOSES QUALITY IMPROVEMENTS AND OTHER CHANGES FOR HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES FOR 2009

The Centers for Medicare & Medicaid Services (CMS) recently issued a proposed rule that will update payment rates for calendar year (CY) 2009 and improve quality of services provided in hospital outpatient departments and ambulatory surgical centers (ASCs). The proposed rule builds on efforts across Medicare to transform the program into a prudent purchaser of health care services, paying based on quality of care, not just quantity of services.

The proposed rule will update rates paid under both the Outpatient Prospective Payment System (OPPS) and the ASC Prospective Payment System (ASC PPS), which will be in the second year of a four-year transition that aligns ASC rates with the ambulatory payment classification (APC) groups that are used to pay for services in hospital outpatient departments.

To read the entire CMS Press release issued today click here:
http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3187&

To read the CMS Fact sheet issued today click here:
http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3188&

For more information on the CY 2009 proposed rule for the OPPS and ASC payment system, please see the CMS Web site at:

OPPS: http://www.cms.hhs.gov/HospitalOutpatientPPS/
ASC payment system: http://www.cms.hhs.gov/ASCPayment/

Pilot Testers Needed!

As you know, the ***Medicare Learning Network*** is constantly developing new training programs and educational materials. As these products are being developed, we would greatly benefit from your input on how they can be improved and made more helpful to you and your association members. **Participating in pilot tests** for our products gives you the opportunity to ensure that we are able to meet your educational needs--and your comments are always greatly appreciated! If you are interested in becoming a pilot tester, please send the following information to the *Medicare Learning Network* at mln@cms.hhs.gov:

- Full name
- Type of provider
- Business
- Address (including city, state, and zip code)
- Phone number and fax number

Thank you for your consideration and we hope to hear from you soon!

I hope you have an enjoyable week ~ Valerie

July 8, 2008

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Accreditation 101: Audio Conference/ Q&A Session

The Centers for Medicare & Medicaid Services (CMS) will host an audio conference/Q&A session regarding Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier accreditation.

This audio conference is the third in a series of four designed to provide guidance to DMEPOS suppliers regarding accreditation. We will be discussing compliance with the DMEPOS Quality Standards and the accreditation process, and will provide ample time to answer questions from the supplier audience. To view the presentation materials, please click on the following link: http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/DMEPOSAccreditationPresentation.pdf .

Please note: This is the same presentation that was made on two prior "Accreditation 101: Audio Conference/ Q&A Session calls". This call will focus on accreditation issues for new suppliers.

Conference call details:

Date: July 15, 2008
Conference Title: DMEPOS Accreditation 101
Time: 1:30-3:00 p.m. EDT

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation. If you cannot attend the call, replay information is available below.

Registration will close at 1:00 p.m. EDT on July 14, 2008, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants need to go to: http://www2.eventsvc.com/palmettogba/071508
2. Fill in all required data.
3. Verify your time zone is displayed correctly the drop down box.
4. Click "Register".
5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Note: Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who will be unable to attend, a replay option will be available shortly following the end of the call**. This replay will be accessible from 4:00 p.m. EDT 7/15/2008 until 11:59 p.m. EDT 7/22/2008.** The call in data for the replay is (800) 642-1687 and the passcode is 49364905.

July 9, 2008

Information Regarding Inpatient PPS Hospital and Long Term Care Hospital Review & Measurement

This is an important message from the Centers for Medicare & Medicaid Services (CMS) regarding some helpful informational materials on the subject of Inpatient Prospective Payment System Hospital and Long Term Care Hospital Review and Measurement. These materials include a fact

sheet and PowerPoint slides. For more information, go to the materials now posted on the CMS website at:

(Fact Sheet)
http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/InpatientReviewFactSheet.pdf

(PowerPoint Slides)
http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/Inpatient_Hospital_Review_Transition.zip.

July 9th Cont'd

2008 PQRI National Provider Call PowerPoint Presentation

2008 Physician Quality Reporting Initiative (PQRI) National Provider Call PowerPoint Presentation-July 9th, 2008 is now available!

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that PowerPoint presentation that will be used during the July 9h, 2008 PQRI National Provider call is now available on the CMS website.

This call will provide information on accessing your 2007 PQRI Feedback Report (for those of you who participated in 2007); an overview of the 2008 PQRI participation options, and a question and answer session.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), which was enacted on December 29, 2007, requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. It also requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting quality measures data through registries.

To access the presentation, go to, http://www.cms.hhs.gov/PQRI, and select the CMS Sponsored Calls tab on the left side of the page. Next, scroll down to the Downloads section under the heading PowerPoint Presentations and select "National Provider Call 07/08/2008"

July 11, 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 it's been a good week for you. Items this week include information on:

- **New from the Medicare Learning Network**
- **CMS Pilot Program Saving Nearly $700 Million In Improper Medicare Payments**
- **Effective August 18, 2008—SADMERC Transition to NAS PDAC**

New from the Medicare Learning Network!

2008 Physician Quality Reporting Initiative (PQRI): New Educational Product is now available!

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the PQRI webpage on the CMS website and is available for download on the PQRI Educational Resources web page, as well as hardcopy ordering through the **Medicare Learning Network** product ordering system.

The *2008 PQRI Reporting Options Quick Reference Chart* is a two-sided laminated reference chart that gives Eligible Professionals and practice staff a quick reference to the new reporting options available for 2008 PQRI with their corresponding alternative reporting periods.

To access this new educational resource, visit http://www.cms.hhs.gov/PQRI on the CMS website and click on the Educational Resources tab. Once on the *Educational Resources* page, scroll down to the "Downloads" section and click on the "2008 PQRI Quick Reference Chart link.

To order a hardcopy of this product, visit http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website and click on the 2008 Physician Quality Reporting Initiative (PQRI) Reporting Quick Option Reference Chart (ICN# 900843)(May 2008) link.

The print version of the revised ***Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians*** **(April 2008)** is now available from the **Medicare Learning Network**. This guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/ , scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

The April 2008 version of the ***Rural Health Clinic Fact Sheet***, which provides information about Rural Health Clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available from the **Medicare Learning Network** in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfctsht08.pdf

NEW REPORT SHOWS CMS PILOT PROGRAM SAVING NEARLY $700 MILLION IN IMPROPER MEDICARE PAYMENTS

The Centers for Medicare & Medicaid Services (CMS) today released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that $693.6 million in improper Medicare payments was returned to the Medicare Trust Funds between 2005 and March 2008. The funds returned to the Medicare Trust Funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

Of the overpayments, 85 percent were collected from inpatient hospital providers, and the other principal collections were 6 percent from inpatient rehabilitation facilities, and 4 percent from outpatient hospital providers.

The program, designed to protect the Medicare Trust Funds and beneficiaries from improper payments, began in California, Florida and New York in 2005 and in July 2007 expanded to Arizona, Massachusetts and South Carolina.

To view this press release in its entirety, please visit CMS' website: http://www.cms.hhs.gov/apps/media/press_releases.asp

For more information on the RAC program and to view the evaluation report, visit: http://www.cms.hhs.gov/RAC

Effective 8/18/08-SADMERC Transition to NAS PDAC

Noridian Administrative Services, LLC (NAS) has been named the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare & Medicaid Services. By August 18, 2008, NAS will perform the following activities that Palmetto GBA, as the Statistical Analysis DME Regional Carrier (SADMERC), currently performs:

- Provide data analysis support to the DME Program Safeguard Contractors (PSCs)
- Guide manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) for Medicare billing purposes, through product reviews and decisions, the DMECS system and the HCPCS Helpline
- Conduct national pricing functions for DMEPOS services
- Assist CMS with DMEPOS fee schedules

Until the PDAC Web site (which will be http://www.dmepdac.com) is launched, please continue to reference the SADMERC Web site, http://www.palmettogba.com/sadmerc, for transition updates and information.

Hope you have a wonderful weekend!

With best regards ~ Valerie

July 15, 2008

An Update on the 2007 PQRI Reporting Period

Medicare Quality Reporting Initiative Pays Over $36 Million To Participating Physicians from the 2007 PQRI Reporting Period

The Centers for Medicare & Medicaid (CMS) today announced payment of more than $36 million in bonus payments to many of the more than 56,700 health professionals who satisfactorily reported quality information to Medicare under the 2007 Physician Quality Reporting Initiative (PQRI).

"Creating a value-based purchasing system is a critical way to improve our health care systems. By collecting quality data, health care providers can use the information to improve the quality care of beneficiaries," said Health and Human Services Secretary Michael Leavitt.

Physicians, physician group practices, and other PQRI eligible professionals should receive their payments by August 2008. The average incentive amount for individual professionals is over $600 and average incentive payment for a physician group practice is over $4,700, with the largest payment to a physician group practice totaling over $205,700.

The PQRI is part of the President's Value-driven Health Care Agenda that seeks to address current problems in the health care sector regarding preventable errors, uneven quality of care and rising health care costs.

More information about the PQRI program, including how eligible professionals can participate and the criteria to qualify for an incentive payment is available at http://www.cms.hhs.gov/PQRI.

To read the entire CMS Press release issued today click here: http://www.cms.hhs.gov/apps/media/press_releases.asp

July 16, 2008

New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008 through December 30, 2008

New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008 through December 30, 2008

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate of -10.6 percent has been replaced with a 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims that have been on hold on a rolling basis (first in/first out) for payment at the -10.6% update level. After your local contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Contractor websites are being updated with the new rates and these should be available shortly.

Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions which may affect you.

Further instructions regarding other provisions of MIPPA will be forthcoming.

July 16th, Cont'd

TECHNICAL CORRECTION TO PREVIOUS MESSAGE – Effective for Dates of Service through date is December 31 2008, not December 30, 2008.

The following is a technical correction to the message sent earlier this morning -- effective for Dates of Service through date is December 31 2008, not December 30, 2008. I apologize for any confusion.

New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008

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Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions which may affect you.

Further instructions regarding other provisions of MIPPA will be forthcoming.

July 16th, Cont'd

Additional Information Regarding the Medicare Improvements for Patients and Providers Act of 2008

Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the Outpatient Prospective Payment System (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing will be complete by September 30, 2008.

More News: The Medicare Improvements for Patients and Providers Act of 2008

Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation

formalized a moratorium on the implementation of the rule. As such, during this time, the carriers and, more recently, Medicare Administrative Contractors (MAC) have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by the Medicare Improvements for Patients and Providers Act of 2008, Section 136, retroactive to July 1, 2008.

A previous communication indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

July 17, 2008

Extension of Therapy Cap Exceptions

Extension of Therapy Cap Exceptions

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. One provision of this legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

July 17th Cont'd

Delay of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming.

July 18th, 2008

Cancellation of Accreditation Deadlines for Second Round of DMEPOS Competitive Bidding

CANCELLED - ACCREDITATION DEADLINES FOR DMEPOS COMPETITIVE BIDDING

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008 to be eligible to submit a bid for the second round of competitive bidding

and must have obtained accreditation by January 14, 2009 to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009 that was previously established by which all DMEPOS suppliers must be accredited is still in effect.

For information about the Medicare DMEPOS Competitive Bidding program, visit http://www.cms.hhs.gov/DMEPOSCompetitiveBid/

July 18th, Cont'd

Your Friday Reading Material

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

Happy Friday everyone ~ once again there has been a lot happening this week which necessitated quite a few messages. Let me wrap up the week with information on:

New from the Medicare Learning Network

Cancellation of Accreditation Deadlines for Round 2 of DMEPOS Competitive Bidding

Ask the Contractor Conference Call on the Section 1011 Program

Rate Year 2009 IPF PPS PC Pricer Now Available

New from the Medicare Learning Network

The ***Critical Access Hospital Fact Sheet*** is now available in print format from the **Medicare Learning Network**. This fact sheet provides information about eligible Critical Access Hospital (CAH) providers; CAH designation; CAH payments; reasonable cost payment principles that do not apply to CAHs; election of Standard Method or Optional (Elective) Payment Method; Medicare Rural Pass-Through funding for certain anesthesia services; Health Professional Shortage Area Incentive payments; Physician Scarcity Area Bonus payments; Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and grants to states under the Medicare Rural Hospital Flexibility Program. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/ , scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Cancelled - Accreditation Deadlines For DMEPOS Competitive Bidding

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008 to be eligible to submit a bid for the second round of competitive bidding and must have obtained accreditation by January 14, 2009 to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009 that was previously established by which all DMEPOS suppliers must be accredited is still in effect.

Ask the Contractor Conference Call on the Section 1011 Program

The National Contractor for the Section 1011 program, TrailBlazer Health Enterprises®, is hosting the second of three **Ask the Contractor Teleconferences (ACT)** on Wednesday, July 30, 2008 from 1-3:00 p.m. (CT).

This **physician-specific** ACT is designed for established Section 1011 physicians and will examine a variety of program issues.

Section 1011 Ask the Contractor Teleconference - PHYSICIANS
Wednesday, July 30, 2008
1-3:00 p.m. (CT)

You may register for the event on the calendar of events page of the Section 1011 Web site**,** http://www.trailblazerhealth.com/Section1011/Default.aspx.

A toll-free, dial-in number will be provided when your registration is approved. A confirmation e-mail with the dial-in information will be sent to the e-mail address provided when you register.

A question-and-answer session will conclude the teleconference. E-mail your questions in advance through the close of business Wednesday, July 23, 2008 to section.1011@trailblazerhealth.com with **Ask the Contractor** in the subject line.

Rate Year 2009 IPF PPS PC Pricer Now Available

The Rate Year (RY) 2009 IPF PPS PC Pricer is now available as of July 2008. The IPF PPS PC Pricer on the page, http://www.cms.hhs.gov/PCPricer/09_inppsy.asp, under "Inpatient Psychiatric Facilities (IPF PPS) PC Pricer" has been posted. If you use the IPF PC Pricer, please go to the page above and download the RY 2009 version of the PC Pricer posted 07/10/2008.

I hope you have a wonderful weekend ~ Valerie

July 18th, Cont'd

Delay of the National DMEPOS Competitive Bidding Program: Claims Processing

Delay of the National DMEPOS Competitive Bidding Program: Claims Processing

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 delays the DMEPOS Competitive Bidding Program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will pay for DMEPOS items, retroactive to June 30, 2008, using the standard DMEPOS fee schedule amounts.

CMS will begin processing all incoming claims under standard FFS rules, no later than July 28, 2008. Any claims that were held will be processed no later than August 4, 2008.

To the extent possible, CMS will also automatically reprocess claims that were paid under the Competitive Bidding Program and those claims denied based solely due to DMEPOS Competitive Bidding Program rules.

Note that in some instances suppliers will need to alert the contractor to claims that should be adjusted.

CMS will soon issue contractor instructions and issue accompanying MLN Matters articles with more information.

July 24, 2008

CMS MIPPA News: Waiving Retroactive Beneficiary Cost Sharing and Ground Ambulance Payment

Waiving Retroactive Beneficiary Cost Sharing Due to Increases in Payment Under MIPPA

The HHS Office of the Inspector General has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF on the web.

Increased Payment for Ground Ambulance Services Under MIPPA
CMS will soon be issuing formal contractor instructions that will incorporate the information contained in this announcement.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. In accordance with Section 146(a) of MIPPA, ambulance fee schedule amounts for ground ambulance services will increase.

The increase will be effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. Specifically,

> For covered ground ambulance transports which originate in a rural area, the fee schedule amounts are increased by 3 percent; and
>
> For covered ground ambulance transports which originate in a non-rural area, the fee schedule amounts are increased by 2 percent.

Contractors have been instructed to hold all ambulance claims affected by these changes, and release them for processing upon implementation of the revised fee schedule files. Contractors have also been instructed to identify and, to the extent possible, automatically reprocess any claims that were paid under the pre-MIPPA fee schedule rates and to complete that reprocessing no later than September 30, 2008. There will, however, be some claims that cannot be automatically adjusted (e.g., the initial claim's submitted charge was below the new fee schedule amount). Ambulance providers should contact their claims processing contractor for guidance on obtaining an adjustment of these claims.

In addition MIPAA Section 146(b)(1) makes changes for certain air ambulance services provided July 1, 2008 – December 31, 2009. CMS will be issuing guidance to contractors on how to implement these changes and will send out another listserv message when additional information is available on this provision.

July 28, 2008

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

Good Monday morning to everyone ~ just a few items to kick off this work week, including information on:

- **Availability of July 2008 Quarterly Provider Specific Files**
- **OPPS Pricer Web Page Update**
- **New Q & A Posted on Reporting of "Charges" On a Hospice Claim**
- **Electronic Prescribing**
- **Transcript Posted for July 15th Special ODF on PQRI**

July 2008 Quarterly Provider Specific Files

The Centers for Medicare & Medicaid Services (CMS) has processed the July 2008 quarterly Provider Specific Files (PSF). **Both text and (new this quarter) Statistical Analysis Software (SAS) data** are available on the CMS website at http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf.asp , under the heading "**Provider Specific Data for Public Use.**" If you use the Provider Specific File data, please go to the page above and download the latest versions of the PSF Files.

Please Note: **New this quarter** -- SAS data sets are now available for Provider Specific File Data, in addition to the text files.

OPPS Pricer Web Page Update

The OPPS Pricer web page has recently been updated to include the July 2008 Provider Specific File. You may go to http://www.cms.hhs.gov/PCPricer/08_OPPS.asp to view the latest update.

New Q & A Posted on Reporting of "Charges" On a Hospice Claim

The Centers for Medicare & Medicaid Services (CMS) recently posted a new Question & Answer providing guidance on CR 5567 as it relates to the reporting of "charges" on the hospice claim. Go to the Hospice Center web page at http://www.cms.hhs.gov/center/hospice.asp on the CMS website.

HHS Takes New Steps to Accelerate Adoption of Electronic Prescribing

Medicare Payments for Successful Electronic Prescribers, Reporting Quality Data are Important Steps Toward a Value-Driven Health Care System

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the Administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value.

Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a 2 percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a one half percent incentive payment in 2013.

Beginning in 2012, eligible professionals who are not successful electronic prescribers will receive a reduction in payment. Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis, if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship.

To read more, see the attached HHS Fact Sheet.

Transcript Posted for July 15th Special ODF: Physicians Quality Reporting Initiative- Participation by the American College of Physicians

The transcript for the July 15th Special ODF: PQRI – Participation by the American College of Physicians has been posted on the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage, under the Downloads section. During the call, as transcribed on page 30, Dr. Hornback inadvertently stated 15% instead of 1.5% in his presentation regarding incentive payment. Please make note of the correct percentage rate 1.5% when reading the transcript. Thank you.

I hope you have a good week ~ Valerie

July 29, 2008

2008 Physician Quality Reporting Initiative (PQRI) ~ National Provider Call to be held on August 13th

2008 Physician Quality Reporting Initiative (PQRI)
National Provider Conference Call with Question & Answer Session

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the sixth in a series of national provider conference calls on the 2008 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:30 p.m. – 5:00 p.m., EDT, on Wednesday, August 13, 2008.

This call will provide an overview of the PQRI provisions in the new Medicare Improvements for Patients and Providers Act (MIPPA) of 2008; information on the E-prescribing measure for 2008 PQRI (measure #125) and proposed measures for 2009 PQRI; incentives for electronic prescribing outlined in the MIPPA; an update on registry reporting for 2008, and a question and answer session.

A PowerPoint slide presentation will be posted to the PQRI web page at, http://www.cms.hhs.gov/PQRI/02_CMSSponsoredCalls.asp, on the CMS website for you to download prior to the call so that you can follow along with the presenters, Dr. Michael Rapp, and Dr. Daniel Green.

Following the presentation, callers will have an opportunity to ask questions of CMS subject matter experts.

Conference call details:

Date: August 13, 2008
Conference Title: 2008 Physician Quality Reporting Initiative National Provider Call
Time: 3:30-5:00 EDT

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation. If you cannot attend the call, replay information is available below.

Registration will close at 3:30 p.m. EDT on August 12, 2008, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants need to go to: http://www2.eventsvc.com/palmettogba/081308

2. Fill in all required data.

3. Verify your time zone is displayed correctly the drop down box.

4. Click "Register".

5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who will be unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 5:30 p.m. EDT 8/13/2008 until 11:59 p.m. EDT 8/20/2008. The call in data for the replay is (800) 642-1687 and the passcode is 55967176.

If you require services for the hearing impaired please send an email to Medicare.TTT@PalmettoGBA.com.

July 31, 2008

Medicare Increases Nursing Home Payment Rates!

Medicare Increases Nursing Home Payment Rates

Medicare payment rates to nursing homes will increase by $780 million next year, the Centers for Medicare & Medicaid Services (CMS) announced today. The boost in payments is the result of a 3.4 percent increase in the annual market basket calculation of the cost of goods and services included in a skilled nursing facility stay. The price of the items in the basket is measured every year and Medicare payments are adjusted accordingly.
A recalibration of the payment categories, intended to correct a previous error that had been proposed for Fiscal Year 2009 has been delayed while CMS continues to evaluate the data. The proposed rule announcing the planned recalibration was published in the Federal Register on May 4, 2008.
To view a copy of the entire press release, please visit
http://www.cms.hhs.gov/apps/media/press_releases.asp

For more information, please visit the following website resources:

CMS Skilled Nursing Facility webpage: http://www.cms.hhs.gov/SNFPPS/.
The copy of the final regulation is available at:
http://www.cms.hhs.gov/SNFPPS/LSNFF/list.asp#TopOfPage

July 31st, Cont'd

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) - CMS ANNOUNCES MORE ACCURATE PAYMENTS FOR INPATIENT REHABILITATION SERVICES IN FY 2009

CMS ANNOUNCES MORE ACCURATE PAYMENTS FOR INPATIENT REHABILITATION SERVICES IN FY 2009

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule to improve the accuracy of payment for services furnished to people with Medicare who need the intensive rehabilitation services provided by Inpatient Rehabilitation Facilities (IRFs). These include patients who are recovering from serious illnesses or injuries, such as stroke, spinal cord injuries, severe burns, amputations and a number of other conditions. There are currently more than 1,200 facilities that are paid as IRFs. CMS projects that Medicare payments to IRFs under this final rule will be approximately $5.6 billion in FY 2009.

To view a copy of the entire press release, please visit
http://www.cms.hhs.gov/apps/media/press_releases.asp

For more information, please visit the following website resources:
The fact sheet is available at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp
CMS Inpatient Rehabilitation Facility webpage at:
http://www.cms.hhs.gov/InpatientRehabFacPPS/.
The copy of the final regulation is available at:
http://www.cms.hhs.gov/InpatientRehabFacPPS/LIRFF/list.asp#TopOfPage

CMS Announcement: Medicare Hospices to See Increase In 2009 Wage Index

Medicare Hospices to See Increase
In 2009 Wage Index, CMS Announces

Hospices serving Medicare beneficiaries will see a 2.5 percent increase in their payments for 2009 according to a final regulation published today by CMS. The increase in the hospice wage index is the net result of a 3.6 percent increase in the so-called "market basket" indicator of cost, offset by a 1.1 percent decrease in payments to hospices as CMS phases out a transitional payment to these providers.

To view a copy of the entire fact sheet, please visit
http://www.cms.hhs.gov/apps/media/fact_sheets.asp

For more information, please visit the following website resources:
CMS Hospice webpage at: http://www.cms.hhs.gov/center/hospice.asp.
The copy of the final regulation is available at:
http://www.cms.hhs.gov/Hospice/RegsNotices/list.asp#TopOfPage

CMS announces several actions to improve the quality of care in hospitals!

MEDICARE AND MEDICAID MOVE AGGRESSIVELY TO ENCOURAGE GREATER PATIENT SAFETY IN HOSPITALS AND REDUCE NEVER EVENTS

The Centers for Medicare & Medicaid Services (CMS) announced today it is taking several actions to improve the quality of care in hospitals and reduce the number of "never events" -- preventable medical errors that result in serious consequences for the patient.

A final acute care inpatient prospective payment (IPPS) rule that went on display today at the Office of the Federal Register for publication August 19, 2008 updates Medicare payments to hospitals for fiscal year (FY) 2009 and provides additional incentives for hospitals to improve the quality of care provided to people with Medicare. As part of these quality

of care incentives, the rule includes payment provisions to reduce never events that occur in hospitals.

In addition to the final rule, CMS today sent a letter to state Medicaid directors providing information about how states can adopt the same never events practices. The letter specifically encourages states to adopt the same non-payment policies outlined in today's final Medicare rule. Nearly 20 states already have or are considering methods to eliminate payment for some never events.

CMS also announced today the opening of a process to develop three National Coverage Determinations (NCDs) that would address Medicare coverage of certain surgical procedures.

The Final Regulation will be published in the *Federal Register* on August, 19, 2008.

The CMS press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

The IPPS rule will be posted at - http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage

NCD Tracking Sheets:

https://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=223&basket=nca:00401N:223:Wrong+Surgery+Performed+on+a+Patient:Open:New:1

https://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=222&basket=nca:00402N:222:Surgery+on+the+Wrong+Body+Part:Open:New:1

https://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=221&basket=nca:00403N:221:Surgery+on+the+Wrong+Patient:Open:New:1