Provider Partnership Program (PPP) E-mail Notification Archives

August 3, 2005

Hi everyone ~ the following three payment regulations recently went on display at the Federal Register and are posted to the CMS website:

CMS-1500-F - Hospital IPPS and FY 2006 Rates
CMS-1502-P - Physician Fee Schedule for CY 2006 (Proposed Rule)
CMS-1290-F - Inpatient Rehab Facilities PPS for FY 2006

Here are the details ~

CMS ANNOUNCES PROPOSED PAYMENT UPDATE AND POLICY CHANGES FOR MEDICARE PHYSICIAN FEE SCHEDULE

The Centers for Medicare & Medicaid Services (CMS) expects to pay approximately $56.5 billion to 875,000 physicians and other health care professionals in 2006, according to a proposed rule released Monday afternoon that would update payment rates and revise payment policies under the Medicare Physician Fee Schedule. The proposed rule would expand Medicare coverage of glaucoma screening; expand access for rural beneficiaries enrolled in Medicare Advantage plans to services of federally qualified health centers (FQHCs); reform payment for multiple imaging procedures performed on a beneficiary at one session; and revise payment for inhalation therapy and end stage renal disease (ESRD) treatment.

The proposed rule indicates that payment rates per service for physicians' services would be reduced by 4.3 percent for 2006, a reduction required by a statutory formula that takes into account substantial growth in overall Medicare spending in 2004.

The proposed rule will be published in the August 8, 2005 *Federal Register*. CMS will accept comments on the proposals until September 30, and publish a final rule later this year.

To view this entire release online: http://www.cms.hhs.gov/media/press/release.asp?Counter=1515

****

CMS ANNOUNCES PAYMENT INCREASES, POLICY CHANGES FOR INPATIENT REHABILITATION FACILITIES

The Centers for Medicare & Medicaid Services (CMS) issued its inpatient rehabilitation facility payment (IRF) final rule which increases payments in Fiscal Year (FY) 2006 on Monday afternoon. The payment policies in this rule help to ensure that Medicare beneficiaries continue to have access to intensive inpatient rehabilitation services when they are needed. With the market basket update, adjustments for coding changes, and change to the outlier threshold, aggregate payments to IRFs in fiscal year 2006 are projected to increase $210 million over FY 2005, a 3.4 percent increase. In this final rule CMS is adopting a number of proposed refinements to the IRF prospective payment system (PPS) that will both increase payments overall, improve the accuracy of Medicare's payments, and ensure continued access to appropriate rehabilitation care. CMS made a number of important changes in response to comments to support these objectives, and to ensure that affected providers have an opportunity to adjust to the changes.

The final rule will be published in the August 15 *Federal Register*. The policies in this final rule will apply to discharges on or after October 1, 2005 and on or before September 30, 2006..

Note: For more information, see *www.cms.hhs.gov/providers/irfpps*.

To view this press release online: http://www.cms.hhs.gov/media/press/release.asp?Counter=1519

****

CMS ANNOUNCES FY 2006 RATE INCREASES FOR INPATIENT STAYS IN ACUTE CARE HOSPITALS

Acute care hospitals that report selected quality data will receive a 3.7 percent increase in payment rates for inpatient services under a final rule issued Monday by the Centers for Medicare & Medicaid Services (CMS). This increase is 0.5 percentage points above the market basket projected in the proposed rule published last May. Aggregate payments to Inpatient Prospective Payment System (IPPS) hospitals in fiscal year (FY) 2006 are expected to increase by $3.3 billion over 2005.

The final rule will appear in the August 12, 2005 *Federal Register*. The new policies and payment rates will become effective October 1, 2005.

Note: For more information, visit the CMS Website at *www.cms.hhs.gov/providers/hipps/default.asp?*

To view this entire press release online:
http://www.cms.hhs.gov/media/press/release.asp?Counter=1517

****

I hope you have a good day ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 5, 2005

Hello everyone. We have scheduled the next Physician Partners meeting for Wednesday, October 5th from 10:00 - 12:00 noon, in Conference Room C-112 at the CMS Single Site in Baltimore. Agenda topics currently include:

- *HIPAA Contingency Plan*
- *2006 Physician Fee Schedule*
- *National Provider Identifier*
- *New Remittance Advice Software*
- *Preventive Services Expanded Benefits*

Because there have been many recent changes in staff both with CMS and the associations, we are also planning to use the first half hour or so for a "Meet & Greet." This will give everyone an opportunity to chat on a less formal level.

I hope this date and time are good for the majority of you. Please feel free to invite anyone else who you believe would be interested in attending. I will need to know, however, exactly who will be attending so that I can submit names to our Security Staff. I would, therefore, appreciate it if you could respond to Mary Loane of my staff (Mary.Loane@cms.hhs.gov) as to whether you will be attending and also submit to her any agenda items you may have. If you will be calling into

the meeting, please let Mary know that as well, as we need to allow for sufficient call-in lines. The call-in number will be provided to you as the meeting time gets closer.

We look forward to seeing you on October 5th ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 9, 2005

Good afternoon everyone. In follow-up to my message last week concerning CMS' decision to end its HIPAA Contingency Plan for claims submissions, I wanted to let you know that we have posted a Medlearn Matters article to provider further details on this subject. The article, MM3956 - Medicare Announces End of HIPAA Contingency Plan for Claims Submissions, can be accessed at
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3956.pdf

****

In other HIPAA-related news, CMS will host a National HIPAA National Provider Identifier (NPI) Roundtable conference call on September 14, 2005 at 2:00 PM ET. The call in number is 1-877-203-0044 and the identification number is 5580762. No cost or registration required.

Hope you enjoy your evening ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 12, 2005

Hello everyone ~ two news items I thought you might be interested in.

CMS ACTS TO IMPROVE QUALITY CARE FOR CHRONICALLY ILL BENEFICIARIES

The Centers for Medicare & Medicaid Services (CMS) recently announced the beginning of a new initiative, Medicare Health Support, designed to help beneficiaries with diabetes and congestive heart failure reduce their health risks and protect their quality of life. Eight Medicare Health Support pilot programs will be offered this year in different areas of the country as free, voluntary support programs, for approximately 160,000 fee-for-service Medicare beneficiaries for three years.

Participation in a Medicare Health Support program will be completely voluntary and will not affect beneficiaries' Medicare coverage, their access to medical services, or their ability to choose their own doctors and other health care providers. The programs are not a new form of insurance plan or HMO and will be available at no charge to beneficiaries who are invited to participate.

More information about the Medicare Health Support initiative is available at http://www.cms.hhs.gov/medicarereform/ccip. Read this entire press release online at: http://www.cms.hhs.gov/media/press/release.asp?Counter=1521

****

CHANGES TO COMPETITIVE ACQUISITION PROGRAM TIMELINE

Effective August 3, 2005, CMS is suspending the current CAP vendor bidding process for which bids were previously due August 5, 2005. Any bids received by CMS will be returned to the bidder without review. At a later time, the CAP website http://www.cms.hhs.gov/providers/drugs/compbid/default.asp will provide updates on revised bidding deadlines and additional information about implementation of CAP.

CMS is suspending the bidding at this time to allow us to more fully review public comments to the CAP IFC (CMS-1325-IFC) as well as to implement further clarifications to the bidding process before we proceed to accept bids from vendors. We will be publishing a notice of the suspension in the Federal Register in the near future.

Please note that the CAP IFC comment period has not been suspended and CMS will continue to accept comments until no later than 5PM on September 6, 2005 as stated in the IFC. A link to the interim final rule is available at http://www.cms.hhs.gov/providers/drugs/compbid/default.asp . The process for submitting comments by mail and e-mail is described at the beginning of the rule. We encourage all interested parties to submit comments.

After we are able to analyze the comments and determine how we can best improve the efficiency and attractiveness of the CAP, we anticipate publishing a final rule in late 2005.

We intend to open the bidding for vendors after the publication of this rule. Although we have not yet set a definite timeline, we anticipate that bids would be due to CMS no earlier than 30 days following the publication of the final rule. After the vendors are announced, we will conduct an election period, during which physicians can voluntarily choose to participate in the CAP program and enroll with a particular vendor. At present, we expect that drugs will first be delivered through the CAP by July 2006.

We will continue to provide updates regarding the implementation of CAP through the CAP website and our pharmacy and physician ODF listservs--***and, of course, the Provider Partners e-mail listing.***

With best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 15, 2005

Below please find information on two new Medlearn Matters articles concerning SNF payments, as well as information on a CMS Proposal that would require nursing homes to vaccinate residents against the flu ~ I hope you find it useful.

Medlearn Matters Articles

New:

MM4010 - October 2005 Quarterly Update to Skilled Nursing Facility (SNF) Consolidated Billing (CB) http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4010.pdf

MM3972 - Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2006

http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3972.pdf

****

CMS PROPOSAL WOULD REQUIRE NURSING HOMES TO VACCINATE RESIDENTS AGAINST THE FLU

Nursing homes serving Medicare and Medicaid residents would have to provide immunizations against influenza and pneumococcal disease to all residents if they want to continue in the programs, according to a proposed rule to be released by CMS in the August 15 *Federal Register*.

Unless refused by the resident or resident's family or for medical reasons, nursing homes would be required to ensure that each resident received the immunizations as a condition of participation in the two programs.

About two million Americans, most age 65 years or older, live in long-term care facilities. People aged 65 years and older account for more than 90 percent of influenza-related deaths in the United States and elderly nursing home residents are particularly vulnerable to influenza-related complications. In addition, the elderly are more likely than younger individuals to die from pneumonia.

In light of these statistics and in line with the agency's Nursing Home Quality Initiative, CMS received input from the Centers for Disease Control and Prevention (CDC) and two of the nation's largest nursing home industry trade groups, the American

Association of Homes and Services for the Aging and the American Health Care Association, in developing the proposed rule.

"Improving immunization is a key element of our quality improvement strategy—a strategy that is focused on preventing illnesses and complications in the first place," said Mark B. McClellan, M.D., Ph.D., administrator of CMS. "The outstanding commitment of the nursing home industry, caregivers and other stakeholders makes clear that his commitment to better quality through more effective immunization is shared and achievable.

"As a physician, I know the impact that influenza and pneumococcal infections can have on the elderly, particularly those in nursing homes," he added. "Greater use of flu shots and pneumococcal vaccine in nursing homes is a proven approach to better health and fewer costly complications for one of our most vulnerable groups of beneficiaries."

In its collaborative effort to improve quality of care, CMS is also encouraging nursing homes to provide influenza vaccine to their healthcare workers. Although the vaccine for these workers will not be required in the proposed regulation, immunizing nursing home workers has been shown to reduce mortality rates among residents of long-term care facilities. Research from last year's flu season revealed that only 36 percent of all healthcare workers were vaccinated against the illness.

"Healthcare workers play a vital role in protecting the health of one of our nation's most vulnerable populations—the elderly and disabled who live in nursing facilities," said Julie Gerberding, M.D., director of the Centers for Disease Control and Prevention. "This initiative is critical to ensuring they receive the best quality healthcare."

A 1999 national nursing home survey showed that 65 percent of residents had documented influenza shots and only 38 percent had been inoculated against bacterial pneumonia. A goal of this proposed rule is to attain a target rate of 90 percent for both vaccinations. As an added incentive to increase immunization rates, in January, CMS increased the average Medicare payment rate for administering each shot from $8 to $18, in addition to a separate payment for the cost of the vaccine. Medicaid payment rates are set independently by each state.

As a Medicare condition of participation, the rule proposes that long-term care facilities ensure that each resident is:

- offered influenza immunization annually;
- immunized against influenza unless medically contraindicated or when the resident or the resident's legal representative refuses immunization;
- offered pneumococcal immunization once if there is no history of immunization; and

- immunized against pneumococcal disease unless medically contraindicated or when the resident or the resident's legal representative refuses immunization.

In the case of a vaccine shortage as declared by CDC, state survey agencies would have the discretion not cite facilities for being out-of-compliance with this requirement.

"Vaccines against these diseases are effective in preventing hospitalizations and death," said Dr. McClellan. "However, many at-risk people are not getting the vaccines they need. This initiative will be critical to maintaining high-quality care in the nation's long-term care facilities."

Because of the impending influenza season, this expedited proposed rule will have a 15-day comment period. To review the proposal, go to the *Federal Register* Web site at
http://www.archives.gov/federal-register

With best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

Two topics that don't necessarily go together but I hope you find both items of interest.

Order Your Posters Now While Supplies Last!

In partnership with CMS, the Social Security Administration has developed a series of posters that direct Medicare beneficiaries where they can call to find out if they are eligible for help with prescription drug costs. These wall posters are suitable for display in physician, provider, or supplier offices, pharmacies, or other health care settings where Medicare beneficiaries will see this information. To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at:
http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS website. ***Remember, we need your help in getting this information out to Medicare beneficiaries with limited income and resources, and encourage you to order and display the posters where Medicare beneficiaries will see them.***

****

New! We have just released a new Special Edition Medlearn Matters article pertaining to the Comprehensive Error Rate Testing (CERT) process. The article,

SE0547 - The Comprehensive Error Rate Testing (CERT) Process for Handling a Provider's Allegation of Medical Record Destruction, is available for viewing at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0547.pdf

Best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 18, 2005

GREAT NEWS!! The Fiscal Intermediary Standard System (FISS) tutorial is now available to Medicare Part A providers.

Fiscal Intermediary Standard System (FISS) is a mainframe standard system that Fiscal Intermediaries use to process Medicare Part A claims.

The FISS Tutorial was developed to introduce the basic concepts of the FISS system and its use in the processing of Medicare claims. Upon completion of the FISS Tutorial, you should have a better understanding of how a Medicare Part A Claim is processed.

This product is available in three formats **free of charge**. These formats include:

Web-based training course that can be viewed through your Internet browser

CD Rom that can be ordered free of charge from the Medicare Learning Network's Medlearn product ordering page

Hard copy transcript that can be printed from your desk top

The FISS tutorial in all three formats, can be accessed on the FISS tutorial web page at www.cms.hhs.gov/medlearn/fiss-tutor.asp on the Centers for Medicare & Medicaid Services website.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov

Phone: (410) 786-6690
FAX: (410) 786-0330

Hi everyone. Just wanted to let you know that we just posted a revised version of the Medlearn Matters Special Edition article # SE0418 - Non-Physician Practitioner Questions and Answers. The revised article can be viewed at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0418.pdf .

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

CMS is pleased to announce that the "***Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals***" is now available to order. This comprehensive guide to Medicare-covered preventive services and screenings is intended to give physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for-service contractors information on coverage, coding, billing, and reimbursement to help them file claims effectively, while also giving providers information that will enable them to encourage utilization of these benefits as appropriate. A downloadable PDF version of the guide is available at http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS website. The Guide is also one of the resources included in the Medicare Preventive Services Resources CD ROM for health care professionals. Copies of both the Guide and the CD ROM may be ordered, free of charge, through the Medicare Learning Network's Medlearn home page at www.cms.hhs.gov/medlearn on the web. ***Order your copies today!***

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 24, 2005

New Medlearn Matters Article for All Providers Regarding Medicare Prescription Drug Coverage

The next in our series of ***Medlearn Matters*** articles on the new Medicare prescription drug coverage is now available. *"Clarification on Part D and Fee-For-Service (FFS) Providers, New Web-based Educational Products, and the Latest Information on Medicare Prescription Drug Coverage – The Seventh in the Medlearn Matters Series"* (SEO557) contains important information on the relationship between Part D and Fee-for-Service providers, as well as the latest educational materials. Visit **Medicare Prescription Drug Coverage Information for Providers** on the Medlearn website to view the article and other drug coverage resources for Medicare providers. For your convenience, I have also attached a copy of the article to this note.

SE0557.pdf (287 KB)

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0557.pdf

SE0557.pdf (287 KB)

August 24, 2005

CMS announces the publication of its new regulation, CMS-3017-IFC, Power Mobility Devices (PMD). This regulation includes new conditions of payment that will affect how DME suppliers dispense and submit claims for PMDs, how physicians and treating practitioners will evaluate beneficiaries for PMDs, and new requirements for PMD prescriptions and the submission of supporting medical record documentation.

CMS has developed several materials for your reference, including a Fact Sheet and Frequently Asked Questions. To view these items—as well as a full copy of the regulation—please visit the "Mobility Assistive Equipment" page on the Medicare Coverage web site at http://www.cms.hhs.gov/coverage/wheelchairs.asp.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 29, 2005

Hi everyone. Just wanted you to know that the September 14, 2005 HIPAA National Provider Identifier (NPI) Roundtable, which I recently told you about, is postponed and will be rescheduled for a later date. For the latest information, keep checking the HIPAA website at http://www.cms.hhs.gov/hipaa/hipaa2/ .

Thanks!

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

August 30, 2005

Hi everyone--here's the press release related to the POV regulation that I notified you of last week. I will be sending you a third announcement related to this subject when the related Medlearn Matters article becomes available, so stay tuned!

CMS ISSUES UPDATED REGULATIONS FOR POWER WHEELCHAIR AND POWER OPERATED VEHICLE CLAIMS

CERTIFICATE OF MEDICAL NECESSITY NO LONGER REQUIRED

The Centers for Medicare & Medicaid Services (CMS) today took another step to streamline and ensure appropriate access for people with Medicare to power operated vehicles – commonly called "scooters" – and power wheelchairs. In an interim final rule with opportunity to comment that went on display today at the *Federal Register*, CMS clarified the requirements for prescribing, supplying, and receiving payment for these vehicles. The interim final rule builds on current clinical standards of care.

"This interim final rule is a critical step in ensuring that people with Medicare have access to appropriate technology to assist them with mobility," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Along with Medicare's decision earlier this year to replace the old 'bed or chair confined' standard with new functional criteria for eligibility, this interim final rule is part of a comprehensive strategy to help Medicare beneficiaries get the mobility assistance equipment they need while avoiding unnecessary administrative burdens and inappropriate Medicare spending. An appropriate professional evaluation and its documentation in the patient's record are the key to the effective use of mobility devices and the quality and continuity of care for our beneficiaries."

CMS is eliminating the requirement that a Certificate of Medical Necessity (CMN) signed by the prescribing physician or other treating practitioner accompany claims for power wheelchairs and scooters. In place of the CMN, the interim final rule describes the clinical documentation from a patient's medical record that must be submitted along with a written prescription to the supplier before the supplier delivers a power wheelchair or scooter to the beneficiary.

"Documentation in the medical record of the beneficiary's need for assistance with mobility in the home, as well as the type of technology needed, not only is the best evidence of medical necessity – it also helps to promote continuity of care for our beneficiaries," said CMS Acting Chief Medical Officer, Barry Straube, M.D. "And we are recognizing this in our payments to providers."

Medicare already pays under the Physician Fee Schedule for the office visit required to evaluate the beneficiary. Because of the changes in the documentation suppliers will need before delivering a power wheelchair or scooter, CMS is authorizing an additional payment to physicians and treating practitioners for preparing and providing the required documentation to the equipment supplier. To receive this payment, the physician or treating practitioner will include a special billing code on the claim for the office visit.

CMS is today notifying physicians and other treating professionals, as well as PMD suppliers, of this interim final rule through its Medicare listserves. In addition, between the issuance of this interim final rule and its effective date in 60 days, CMS will target educational efforts to physicians and other practitioners who prescribe power wheelchairs and power scooters as well as to suppliers of PMD, to help them understand the new criteria and new documentation requirements. CMS will also provide billing instructions for suppliers before the implementation date.

To help suppliers evaluate and document the patient's need for a particular type of technology, the contractors who process durable medical equipment claims will issue specific guidance about what information from the beneficiary's medical record is needed to demonstrate the medical necessity of the equipment. This guidance will underscore that an appropriate coverage determination for these products will take into account the patient's medical history, elements of a

physical assessment such as strength and range of motion, a functional needs assessment as documented in the medical record, as well as the availability of other types of devices.

In early September, CMS will hold a special Open Door Forum to address power wheelchair and power scooter issues. Open Door Forums offer physicians, suppliers and other stakeholders the opportunity to participate in person or by conference call in a discussion with senior staff about Medicare policies.

The interim final rule issued today is the latest action CMS is taking to implement a Power Wheelchair Initiative first announced in April 2004. That multi-pronged initiative is focused on improving coverage, payment policies, and quality of suppliers of power wheelchairs and power scooters. In addition to developing new, functional criteria for coverage, CMS is adopting new billing codes for power wheelchairs and power scooters that will allow Medicare to differentiate among types of equipment with different features and pay more accurately depending on the characteristics of the particular chair.

The interim final rule also implements provisions in the Medicare Modernization Act of 2003 (MMA) affecting power wheelchairs and power scooters, including a provision requiring a physician or treating practitioner (who can be a physician assistant, nurse practitioner, or clinical nurse specialist) to conduct a face-to-face examination of the beneficiary before prescribing a power wheelchair or power scooter.

The interim final rule also eliminates a restriction that allows only a specialist in physical medicine, orthopedic surgery, neurology or rheumatology to prescribe a power scooter. This restriction, which no longer reflects current standards of care, has created barriers to appropriate prescribing of equipment to meet a patient's needs. The new rule allows both physicians and treating practitioners to prescribe a power wheelchair or power scooter. Finally, the interim final rule requires a supplier, before billing Medicare, to obtain a written prescription, signed and dated by the physician or treating practitioner who performed the face-to-face examination, within 30 days of the examination.

The actions CMS is taking today underscore the principle that the beneficiary's physician or treating practitioner is in the best position to evaluate and document the beneficiary's clinical condition and medical needs. Good medical practice requires that this evaluation be adequately documented. Thus, to minimize the documentation requirements for providers while assuring that documentation is adequate, physicians and treating practitioners will now submit copies of relevant existing documentation from the beneficiary's medical record, rather than having to transcribe medical record information onto a separate form such as a CMN.

The interim final rule will be published in the August 26 *Federal Register*, and will become effective for services on or after October 25. Comments will be accepted until November 25, and a final rule will be published at a later date.

Note: The Interim Final Rule and a Fact Sheet will be posted on the CMS Website at:

www.cms.hhs.gov/coverage/wheelchairs.asp

This press release is available online at:
http://www.cms.hhs.gov/media/press/release.asp?Counter=1540

Best wishes to everyone ~ Valerie

Valerie A. Hart, Director
Division of Provider Information

Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330