

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


**August 1, 2007**

### **Your Mid-Week News Update**

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

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*Happy August everyone! I'm sending these news items a bit early this week as some of the items are date sensitive, particularly the NPI National Roundtable/Q&A session on common billing errors for Medicare Fee-For-Service providers that will take place tomorrow, Tuesday, August 2, 2007. In addition to information on this NPI event, I have included information on:*

- **Skilled Nursing Facilities & Inpatient Rehabilitation Facilities Prospective Payment Systems FY 2008**
- **Release of CMS' Final National Coverage Determination for the Use of Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions**
- **The Latest from the Medicare Learning Network** 

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

CMS will host a National Roundtable/Q&A session on common billing errors for Medicare Fee-For-Service providers.

**Date:** August 2, 2007  
**Conference Title:** Fee For Service Medicare NPI Q&A Session: Common Billing Errors  
**Time:** 2:00-3:30 p.m. EDT

It is recommended that you review a recent MLN Matters article on this topic prior to participating in this call. You can download and print a copy of this article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website.

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 2:00 p.m. EDT on August 1, 2007, 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/>
2. Select your time zone from the drop down box at the top of the page to ensure that the time of the call is specific to your time zone.
3. Click "**Fee For Service Medicare NPI Q&A Session: Common Billing Errors**".
4. Fill in all required data.
5. Verify your time zone is displayed correctly the drop down box.
6. Click "Register".
7. 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 they may have gotten caught in that.

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. EST 08/02/2007 until 11:59 p.m. EST 08/07/2007. The call in data for the replay is (800) 642-1687 and the passcode is 7025327.

### ***Still Confused?***

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page [www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand) on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

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**Skilled Nursing Facilities & Inpatient Rehabilitation Facilities Prospective Payment Systems FY 2008**

**CMS INCREASES MEDICARE PAYMENTS FOR BENEFICIARIES USING SKILLED NURSING FACILITY CARE FOR 2008; ACCURATE PAYMENTS WILL ENSURE PROGRAM EFFICIENCY, QUALITY, AND SUSTAINABILITY**

Medicare payments to nursing homes will increase by approximately \$690 million in fiscal 2008 under new rates recently finalized by the Centers for Medicare & Medicaid Services (CMS). This 3.3 percent increase will affect payment rates to nursing facilities that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems.

The final rule for the skilled nursing facility prospective payment system (SNF PPS) was recently placed on display at the Office of the Federal Register and will be published in the *Federal Register* on Friday, August 3, 2007.

CMS Press Release, please see: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)  
SNF PPS Information Page on CMS Website: <http://www.cms.hhs.gov/snfpps/>  
DIRECT Link to the SNF PPS Final Regulation:  
<http://www.cms.hhs.gov/SNFPPS/downloads/cms-1545-f-display.pdf>

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**CMS INCREASES PAYMENTS TO IN-PATIENT REHABILITATION FACILITIES FOR FISCAL YEAR 2008; ACCURATE PAYMENTS WILL ENSURE PROGRAM EFFICIENCY, QUALITY, AND SUSTAINABILITY**

Inpatient rehabilitation facilities (IRFs) are projected to receive approximately \$6.4 billion in payments from the Medicare program in fiscal year (FY) 2008, under a final rule recently announced by the Centers for Medicare & Medicaid Services (CMS). The final rule updates payment rates and modifies payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007 through September 30, 2008. The rule's provisions are estimated to increase Medicare payments to approximately 1,220 IRFs in FY 2008 by approximately \$150 million.

The final rule for the inpatient rehabilitation facility prospective payment system (IRF PPS) was recently placed on display at the Office of the Federal Register and will be published in the *Federal Register* on Tuesday, August 7, 2007.

You may also access this material as well as additional background information on the CMS website by visiting the following links:

CMS Press Release: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)  
IRF PPS Information Page on CMS Website: [www.cms.hhs.gov/InpatientRehabFacPPS/](http://www.cms.hhs.gov/InpatientRehabFacPPS/)  
DIRECT Link to the IRF PPS Final Regulation:  
<http://cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f-display.pdf>

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**MEDICARE POSTS FINAL NATIONAL COVERAGE DETERMINATION FOR THE USE OF ERYTHROPOIESIS STIMULATING AGENTS IN CANCER AND RELATED NEOPLASTIC CONDITIONS**

The Centers for Medicare & Medicaid Services (CMS) recently announced its final national coverage determination (NCD) for the use of Erythropoiesis Stimulating Agents

(ESA) in cancer and related neoplastic conditions. This NCD was opened in response to Food and Drug Administration's (FDA) boxed warning regarding the use of ESAs.

CMS published its proposed NCD on May 14, 2007, which opened a 30-day public comment period. The initial decision proposed that Medicare coverage of ESA treatment in beneficiaries with cancer should be limited to circumstances in which the treatment is not likely to worsen the cancer and in cases where the beneficiary's anemia is responsive to the ESA. More than 2,600 public comments were received. After reviewing these public comments and additional evidence, CMS has modified the proposed coverage decision.

The final NCD no longer distinguishes between those cancers that have erythropoietin receptors and cancers without such receptors. In addition, CMS has made no determination regarding ESA use for myelodysplastic syndrome (MDS). MDS is a premalignant syndrome that transforms into acute myeloid leukemia in many patients. In cases where no determination is made, Medicare local contractors have the discretion to make reasonable and necessary determinations regarding ESA use.

The final NCD provides coverage with restrictions for the treatment of anemia secondary to myelosuppressive anticancer chemotherapy in certain cancer conditions, such as solid tumors, multiple myeloma, lymphoma and lymphocytic leukemia. The NCD details these restrictions, which include limiting initiation of ESA therapy to when the hemoglobin level is less than 10g/dL, limiting the ESA treatment duration to a maximum of 8 weeks after a chemotherapy session ends, limiting the starting dose to the FDA recommended starting dose, and limiting dose escalation levels.

"Our goal was to maintain physician autonomy while ensuring the safety of our Medicare beneficiaries in light of the FDA boxed warnings," CMS Acting Deputy Administrator Herb Kuhn said. "This final NCD is based on the best science to date and consistent with FDA labeling and warnings. We look forward to further reports from FDA and are prepared to make additional modifications to our policies to ensure that Medicare patients receive the best and most effective treatments."

CMS continues to be concerned with the safety signals highlighted by the FDA boxed warnings and encourages treating physicians to review the warnings and to take them into account when prescribing ESAs for their patients.

ESAs are marketed in the US as Epogen, Aranesp and as Procrit. They are man-made versions of erythropoietin, a hormone that is produced in the kidney and stimulates the bone marrow to make more red blood cells.

ESAs are FDA approved to reduce the need for blood transfusions in patients with end-stage renal disease, chronic kidney disease, patients with cancer on chemotherapy, patients scheduled for some major surgeries and patients with human immunodeficiency virus that are using Zidovudine (also known as AZT).

Additional information from FDA can be found at:  
[www.fda.gov/cder/drug/infopage/RHE/default.htm](http://www.fda.gov/cder/drug/infopage/RHE/default.htm).

The CMS decision is effective as of July 30, 2007. Details of the full coverage policy are available at the CMS coverage website at  
<https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=203>.

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**New from the Medicare Learning Network!**



The May 2007 ***Quick Reference Information: Medicare Preventive Services*** laminated chart is now available to order or download from the Medicare Learning Network. To order, go to the “MLN Product Ordering Page” located at  
[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) or to view online, go to  
[http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf) on the CMS Website.

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*I hope you enjoy the rest of your week ~ Valerie*

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## **Additional NPI Information**

**CMS is delaying the deployment of the NPI Registry and the dissemination of FOIA-disclosable health care provider data from the National Plan and Provider Enumeration System (NPES). Additional information will be forthcoming on the Data Dissemination section of the NPI page at  
[http://www.cms.hhs.gov/NationalProvIdentStand/06a\\_DataDissemination.asp](http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp) of the CMS website.**

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### ***Still Confused?***

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page [www.cms.hhs.gov/NationalProviderIdentifierStand](http://www.cms.hhs.gov/NationalProviderIdentifierStand) on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

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**August 2, 2007**

## **CMS ANNOUNCES PAYMENT REFORMS FOR INPATIENT HOSPITAL SERVICES IN 2008**

**REFORMS CONTINUE TRANSITION TO MORE ACCURATE PAYMENT SYSTEM; PROMOTE  
QUALITY CARE FOR ALL HOSPITALIZED PATIENTS**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on August 1, 2007 that takes significant steps to improve the accuracy of Medicare's payment under the acute care hospital inpatient prospective payment system (IPPS), while providing additional incentives for hospitals to engage in quality improvement efforts.

"The IPPS payment reforms we are making today finalize the changes we proposed in April and build upon three years of consistent, incremental improvements to Medicare inpatient hospital payments," CMS Acting Deputy Administrator Herb Kuhn said. "With these changes – first proposed by the Medicare Payment Advisory Commission in 2005 – Medicare payments for inpatient services will be more accurate and better reflect the severity of the patient's condition."

The IPPS payment reforms would restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient's condition. In addition, the rule includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital.

Publication date for this rule will be August 22, 2007.

To read the CMS Press Release issued today, click here:

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

To read the CMS Fact Sheets issued today, click here:

[http://www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp)

To read the rule click here:

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

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

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

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**August 8, 2007**

## **Dissemination of Data from the National Plan and Provider Enumeration System (NPPES) to Begin September 4, 2007**

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

***UPDATE!***

### ***Dissemination of Data from the National Plan and Provider Enumeration System (NPPES) to Begin September 4, 2007***

NPPES health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI Registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.

We must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI Registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits no later than Monday, August 20, 2007. Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

Health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007 (found on the CMS NPI web page at [http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES\\_FOIA\\_Data%20Elements\\_062007.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf)) for assistance in making their edits. Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, OR 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)

The delay in the dissemination of NPPES data does not alter the requirement that HIPAA covered entities must comply with the requirements of the NPI Final Rule no later than May 23, 2008. All NPI contingencies that may be in place must be lifted by that date.

***Still Confused?***



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**August 7, 2007**

### **Some Time-Sensitive News Items**

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

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*Hi everyone! I'm sending these news items today due to the date sensitivity of some of them. Below you will find information on:*

- *Presentation materials for the CMS Special Open Door Forum on Proposed Clinical Research Policy National Coverage Determination (CRP NCD) scheduled for August 7, 2007 at 2:00 PM ET*
- *Upcoming Workshops on CAP for Part B Drugs and Biologicals*
- *Results of the Medicare Contractor Provider Satisfaction Survey (MCPSS)*

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**Presentation materials for the CMS Special Open Door Forum on Proposed Clinical Research Policy National Coverage Determination (CRP NCD) scheduled for August 7, 2007 at 2:00 PM ET has been posted on the CMS website at <http://www.cms.hhs.gov/ClinicalTrialPolicies/> under the "Downloads" section.**

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**Noridian Administrative Services, the designated carrier for the CAP, offers interactive, online workshops about the CAP for Part B Drugs and Biologicals. These workshops train CAP vendors and elected physicians on a variety of CAP topics, and NAS staff can also answer questions. Interested parties may view additional information about and register for these workshops at [https://www.noridianmedicare.com/cap\\_drug/train/workshops/index.html](https://www.noridianmedicare.com/cap_drug/train/workshops/index.html)**

**Upcoming workshops will be held on the following dates:**

- 8/8/07 at 2:00 pm CT
- 9/12/07 at 2:00 pm CT
- 10/18/07 at 12:00 pm CT

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**Most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors, the Centers for Medicare & Medicaid Services (CMS) has reported. The Medicare Contractor Provider Satisfaction Survey (MCPSS), distributed by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.**

**Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.**

**The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.**

**The full results of the 2007 survey are now available at [www.mcpsstudy.org](http://www.mcpsstudy.org).**

**In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008**

***MCPSS implementation, you have an opportunity to help CMS improve service to all providers.***

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**August 8, 2007**

## **NPI: The Importance of Reporting Medicare Legacy Numbers in NPPES**

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

### ***Information for Medicare Providers Regarding the Importance of Reporting Legacy Numbers in NPPES***

The reporting of legacy numbers in the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields in the National Plan and Provider Enumeration System (NPPES) will assist Medicare in successfully creating linkages between providers' NPIs and the identifiers that Medicare has assigned to them (such as PINs).

You should be aware that if you remove your legacy numbers from the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields, linkages that Medicare has established using the reported Medicare legacy numbers will be broken and your Medicare claims could be rejected.

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page [www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand) on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

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**August 9, 2007**

## **2007 Physician Quality Reporting Initiative (PQRI) Update**

### **2007 Physician Quality Reporting Initiative (PQRI) Update**

It's been one month since reporting quality data codes for the 2007 Physician Quality Reporting Initiative (PQRI) on claims for dates of service starting July 1 through December 31, 2007 began. Eligible professionals participating in the 2007 PQRI indicate that the PQRI Tool Kit and Data Collection worksheets are an asset to successful reporting. Provider organizations report successful reporting by their members. Information about the 2008 PQRI was released in the Notice of Proposed Rulemaking for the 2008 Medicare Physician Fee Schedule.

To ensure successful reporting, the Centers for Medicare & Medicaid Services (CMS) would like to bring to your attention the following items:

#### **Use of Modifiers with PQRI Quality Data Codes**

The PQRI quality data codes should only be reported with CPT II modifier(s) (1P, 2P, 3P or 8P), if applicable. If any other modifier, i.e. CPT I modifier or HCPCS Level II modifier, is placed on the same line as a PQRI code, it may cause the claim to be rejected or denied as an invalid procedure/modifier combination.

#### **Reminder: PQRI Letter to Medicare Beneficiaries**

CMS has posted a letter to Medicare beneficiaries with important information about the PQRI at, <http://www.cms.hhs.gov/PQRI>, on the CMS website. The letter is from Medicare to the patient explaining what the program is, and the implications for the patient. Physicians may choose to provide a copy to their patients in support of their PQRI participation.

#### **Question of the Week**

**Question:** The 1.5% bonus is subject to a cap. How and when will CMS calculate the cap for an individual eligible professional?

**Answer:** The bonus cap calculation is defined as follows: (the individual's instances of reporting quality data) multiplied by (300%) multiplied by (the national average per measure payment). The third factor, the "national average per measure payment amount" can only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by (the total number of instances where data were reported by all participants in the program for all measures during the reporting period.)

Because the "national average per measure payment amount" is not yet available, the following is a hypothetical example:

Example:

- Dr. Smith had \$400,000 in allowed charges during the PQRI reporting period.
- The 1.5% potential bonus is \$6000.
- Dr. Smith reported quality data codes in 500 instances.
- The national average per measure payment amount for 2007 was calculated in CY 2008 and turned out to be \$100 (\$100 M total national allowed charges claims submitted from July through December, divided by, 1 million instances of PQRI quality data codes being reported in the same time period).
- The cap for Dr. Smith is \$150,000 (500 x 3 x \$100).
- The bonus paid to Dr. Smith in early CY 2008 is \$6,000.

### **How to View the Measures and Specifications**

To view the entire list of 2007 PQRI quality measures and the associated measure specifications, visit the PQRI website at, <http://www.cms.hhs.gov/PQRI>, and click on the "Measures/Codes" section of the page.

### **How to View the List of Eligible Professionals**

To see the complete list of eligible professionals who may choose to participate in the 2007 PQRI, visit the PQRI website at, <http://www.cms.hhs.gov/PQRI>, and click on the "Eligible Professionals" section of the page.

### **PQRI Resources**

New information is continually added to the most reliable source of information for the 2007 PQRI, the CMS website, <http://www.cms.hhs.gov/PQRI>. Here you will find new

and revised Frequently Asked Questions, updates on issues related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in the 2007 PQRI.

## **General Information**

### ▪ **Rejected Claims**

Fee-for-Service Medicare claims can be rejected by contractors for a variety of reasons including: incorrect billing information, terminated provider, the beneficiary is not eligible for Medicare or the claim was sent to the wrong contractor. If a provider has questions about a claim rejected by a Medicare Fiscal Intermediary, Carrier or Administrative Contractor, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.

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**August 13, 2007**

## **A Few Items to Get Your Week Started**

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

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*Happy Monday everyone! Just thought I'd start the week off with some health reminders and new products, including information on:*

- National Immunization Awareness Month
- The Latest from the Medicare Learning Network
- New Beneficiary-Oriented Publication on Medicare Drug Coverage Under Medicare Part A, Part B and Part D



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### **Vaccines Aren't Just for Kids!**

**August is National Immunization Awareness Month!** Too many adults become ill, disabled, and die each year from diseases that could have been prevented by vaccines. Everyone from the very young to senior citizens can benefit from immunizations. While many consider this to be a time to ensure that children are immunized for school, National Immunization Awareness Month is the perfect time to remind patients, health care employees, family members, friends, co-workers and others to take advantage of opportunities to get up-to date on their vaccinations.

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary co-insurance or co-payment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or co-payment applies for hepatitis B vaccination after the yearly deductible has been met.

Disease prevention is key to public health. It is always better to prevent a disease than to treat it. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high risk persons if five (5) years have passed since their last vaccination.

### **How Can You Help?**

As a health care professional, you can help your Medicare patients and others understand the importance of disease prevention through immunizations. Your recommendation is the most important factor in increasing immunization rates among adults. You can help your Medicare patients take full advantage of the Medicare benefits that are right for them, including an annual influenza vaccination, a pneumococcal vaccination and the hepatitis B vaccination (for beneficiaries at high to intermediate risk for contracting the disease) by encouraging utilization of these benefits as appropriate.

### **For More Information**

- For more information about Medicare's coverage of adult immunizations, including coverage, coding, billing and reimbursement, please visit the following CMS websites
  - The MLN Preventive Services Educational Products Web Page ~  
[http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp)
  - Adult Immunizations ~  
[http://www.cms.hhs.gov/AdultImmunizations/01\\_Overview.asp](http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp)
- For information to share with your Medicare patients, please visit [www.medicare.gov](http://www.medicare.gov) on the Web.
- To learn more about National Immunization Awareness Month, please visit <http://www.cdc.gov/vaccines/events/niam/default.htm#overview> on the Web.

Thank you for partnering with CMS as we strive to increase awareness and promote utilization of vaccines that can prevent infectious disease and save lives.

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### **New from the Medicare Learning Network**



#### ***➤ Two MLN web-based training (WBT) courses are now available with continuing education credits:***

- **Certificate of Medical Necessity (CMN) WBT**

The CMN WBT course contains information about the Certificate of Medical Necessity, commonly known as a CMN. This course will be helpful to physicians, health care professionals, and medical administrative staff in the completion, submission and maintenance of the documentation required to verify the CMN.

- **Uniform Billing (UB)-04 WBT**

The UB-04 version of the Centers for Medicare & Medicaid Services (CMS) Form 1450 web-based training course will be useful for health care administrators, medical coders, billing and claims processing personnel and other medical administrative staff who are responsible for submitting Medicare institutional claims for Medicare payment. The UB-04 WBT addresses hard copy and electronic billing requirements for Medicare institutional providers (i.e., hospitals, skilled nursing facilities, end stage renal disease providers, home health agencies, hospices, outpatient rehabilitation clinics, etc).

Both WBTs are now available with continuing education credits and can be accessed through the MLN Web Based Training Modules link at [www.cms.hhs.gov/MLNProducts](http://www.cms.hhs.gov/MLNProducts) under the "Related Links Inside CMS" section.

#### ***➤ The following publications are now available on the MLN Products Web page:***

- ***"The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (July 2007 version)"*** -- This guide offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, fraud, abuse, inquiries, overpayments, and appeals. It is available at <http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf> (1.36MB).
- ***"The Facilitator's Guide - Companion to the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals"*** -- This guide includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program. It is also now available at <http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?itemID=CMS061390>.



- ***“Medicare Billing Information for Rural Providers, Suppliers, and Physicians,”*** which consists of charts that provide billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, and Critical Access Hospitals, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf> ..

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### **Beneficiary-Related Information**

A new partner tip sheet, ***“Information Partners can Use: Medicare Drug Coverage Under Medicare Part A, Part B and Part D,”*** has been developed to provide an overview on the drugs covered within each of the Medicare program components. This tip sheet was requested to help clarify drug coverage for providers and partners assisting beneficiaries with chronic diseases and drug coverage enrollment.

I have attached a copy of the tip sheet for your convenience. It is also posted at <http://www.cms.hhs.gov/Partnerships/PFP/list.asp> on the CMS Website.



11315-P 508.pdf

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*Well, that's all for now. I hope everyone has a good week!*

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Visit the [Medicare Learning Network](#) ~ it's free!

**August 17, 2007**

# Satellite Broadcast for Caregivers

## *SATELLITE BROADCAST*

**Wednesday, September 19, 2007**

**1:00 – 3:30 p.m. Eastern Time**

### *Objectives*

The New Freedom Initiative (NFI) Subcommittee on Caregiving presents this broadcast designed to bring awareness to the range of programs and services the Department of Health and Human Services (DHHS) offers that support caregivers across the lifespan. NFI is a government-wide effort to eliminate the barriers that prevent people with disabilities from participating in community life. A panel of experts will provide information about these programs to increase knowledge of partners and providers, and improve service delivery for caregiving Americans.

### *Panelists* *(In order of appearance)*

**Kerry Weems**, Administrator Nominee for the Centers for Medicare & Medicaid Services (CMS), and

**Josefina Carbonell**, Assistant Secretary for Aging for the Administration on Aging (AoA), will introduce the Department of Health and Human Services (DHHS) programs that support caregivers across the lifespan.

**Margaret Giannini**, MD, Director, DHHS Office on Disability, will provide an overview of the New Freedom Initiative.

**Gail Gibson Hunt**, National Alliance for Caregiving, will set the current context for caregiving in the United States.

**Rick Greene**, AoA, will describe and explain the National Family Caregiver Support Program at AoA, including program background, new eligibility requirements, services provided, and how to access these services.

**Susan Hill**, CMS, will discuss the home and community based Medicaid waiver program and its impact on family caregivers.

**Susie Butler**, CMS, will review Medicare prescription drug coverage, preventive services, Medicare Advantage, and new developments in “My Health.My Medicare.”

**Gary Quinn**, Indian Health Service, will describe the caregiver support programs within the Indian Health System as well as programs inside and outside tribal communities.

**Yvonne Jackson**, AoA, will summarize the Native American Caregiver Support Program at AoA, including its mission, eligibility requirements, and services provided through the program.

**Faith McCormick**, Administration on Developmental Disabilities, will discuss how caregivers for persons with developmental disabilities can be supported and access available resources.

**Diana Denboba**, Health Resources and Services Administration (HRSA), will discuss HRSA’s support for family caregivers of children with special health needs.

### **More Information**

To register and to find more information on the broadcast and where it can be viewed, please go to:

<http://www.cms.hhs.gov/apps/events/event.asp?id=378> .

If you have any questions, please email us at [caregivers@cms.hhs.gov](mailto:caregivers@cms.hhs.gov) or contact:

- Spencer Schron at (410) 7861075
- Debbi Oxenreider at (202) 2052118
- Rick Greene at (202) 3573586

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**August 20, 2007**

## **Educational Product Update**

The 2nd Edition of “***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals***” is now available in downloadable format from the Centers for Medicare & Medicaid Services, Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to [http://www.cms.hhs.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf) on the CMS website.

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Visit the [Medicare Learning Network](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf) ~ it's free!

## **HHS and DOJ Announce Initiative to Fight Infusion Fraud Therapy**

### HHS and DOJ Announce Initiative to Fight Infusion Fraud Therapy

Today, Health and Human Services Secretary (HHS) Mike Leavitt announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers there will be required to reapply to be a qualified Medicare infusion therapy provider.

“HHS continues to work with the Department of Justice (DOJ) to protect the public and Medicare by stopping fraud before it happens,” Secretary Leavitt said. “This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system.” The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership; have owners, partners, directors or managing employees who have committed a felony, or no longer meet each and every provider enrollment requirement will have their billing privileges revoked.

The DOJ is supporting HHS's new controls through a surge in prosecutions for health care fraud in South Florida. In May, the DOJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the "phase one" Strike Force in Miami last March, DOJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than \$345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

For your convenience, I have attached copies of the HHS Press Release and Fact Sheet on this topic.

Please Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.



FINAL\_RELEASE  
-INFUSION 8-20-07.p



FS - INFUSION  
8-20-07.pdf

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**August 24, 2007**

**Your Friday Reading Materials**

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

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*Hello everyone! A very diverse selection of items this week, including information on:*

- **“Ask the Contractor Teleconference” on the Section 1011 Program**
- **Participant Recruitment for Post Acute Care Payment Reform Demonstration**
- **Medicaid Implementation of Tamper-Resistant Prescription Pads**
- **Improving Beneficiary Access and Quality and Efficiency of Care for Medicare Home Health Services**
- **Certification Request for Current Medicare-Approved Organ Transplant Centers Under the New Rule**
- **An Interesting Article By One of CMS’ Own**

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**“Ask the Contractor Teleconference” on the Section 1011 Program**

The National Contractor for the Section 1011 program, TrailBlazer Health Enterprises, is hosting the first of three "Ask the Contractor Teleconferences (ACT)" on **Thursday, August 30, 2007** from **1:00 – 3:00 p.m. (CT)**.

This hospital-specific, question-driven ACT provides a program overview and updates and offers providers the opportunity to participate in a live question and answer segment.

Questions should be submitted in advance through the close of business Friday, August 24, 2007. E-mail questions to <<mailto:section.1011@trailblazerhealth.com>> with the subject titled “Ask the Contractor.” A live question and answer session will conclude the ACT, but time is limited. Send your questions in advance to ensure they are answered.

**Section 1011: Ask the Contractor Teleconference - Hospitals**  
**Thursday, August 30, 2007**  
**1:00 – 3:00 p.m. (CT)**

Register for the event on the calendar of events page of the Section 1011 website:  
<<http://www.trailblazerhealth.com/section1011>>

A toll free dial-in number and participant code will be provided when your registration is approved. A confirmation e-mail with this information will be sent to the e-mail address provided upon registration

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**CMS ANNOUNCES THE START OF PARTICIPANT RECRUITMENT  
FORPOST ACUTE CARE PAYMENT REFORM DEMONSTRATION**

The Centers for Medicare & Medicaid Services (CMS) recently announced the start of participant recruitment for the Post Acute Care Payment Reform Demonstration (PAC-PRD). Participating providers include acute care hospitals

and four post-acute care (PAC) settings -- Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

The Post Acute Care Payment Reform Demonstration was mandated by Congress in the Deficit Reduction Act of 2005. Recommendations generated by the demonstration will be included in as report to Congress that also is mandated as part of the same law.

At this point, CMS is attempting to recruit providers to participate in this data collection effort. Participation is voluntary. CMS does not envision exercising any waivers of payment rules for this project. Providers may express interest in participating. In addition, providers may also be targeted for recruitment from analysis of Medicare administrative files and will be contacted. Final selection of the provider participants will occur in the fall of 2007. Providers interested in potentially participating in the 2008 demonstration should contact Barbara Gage, Ph.D., Principal Investigator at RTI by emailing [PAT-COMMENTS@RTI.ORG](mailto:PAT-COMMENTS@RTI.ORG).

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#### **CMS Releases Guidance to State Medicaid Directors on Implementing Tamper-Resistant Prescription Pads**

The Centers for Medicare & Medicaid Services (CMS) issued guidance, through a State Medicaid Director Letter, concerning section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, which requires that all written, non-electronic prescriptions for Medicaid outpatient drugs must be executed on tamper-resistant pads in order for them to be reimbursable by the federal government. The Letter gives baseline requirements to States to define and implement tamper-resistant prescription pads.

Below are links to the State Medicaid Director Letter and an informational background document for State health policy makers that includes a checklist of questions to ask to begin implementation.

State Medicaid Director Letter: <http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf>

State Health Policymakers Backgrounder:  
<http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Tamper.pdf>

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#### **CMS ANNOUNCES PAYMENT CHANGES FOR MEDICARE HOME HEALTH SERVICES**

IMPROVING BENEFICIARY ACCESS AND QUALITY AND EFFICIENCY OF CARE

#### **CMS ANNOUNCES PAYMENT CHANGES FOR MEDICARE HOME HEALTH SERVICES, IMPROVING BENEFICIARY ACCESS AND QUALITY AND EFFICIENCY OF CARE**

The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule to refine and update the Home Health Prospective Payment System (HH PPS) for Calendar Year (CY)

2008. This final rule reflects the ongoing efforts of CMS to support beneficiary access to home health services and improve the quality and efficiency of care provided to Medicare beneficiaries through more accurate payments for services rendered. Refinements to the Medicare HH PPS as well as the annual update to the Medicare payment rates for home health services will disburse an estimated additional \$20 million in payments to home health agencies in CY 2008.

The final rule with comment was issued at 4:00 pm on August 22, 2007. A link to the regulation and accompanying documents is available on the CMS website at:

<http://www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/itemdetail.asp?itemID=CMS1202451>

To view the entire Press Release: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

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**COUNTDOWN UNDERWAY FOR CURRENT MEDICARE-APPROVED  
ORGAN TRANSPLANT CENTERS TO REQUEST CERTIFICATION UNDER  
THE NEW RULE**

**All** hospital transplant centers currently approved for Medicare participation (approved either under the ESRD Conditions of Coverage or the National Coverage Decisions) **must** submit a request for **new** approval under the Conditions of Participation established by the new regulation that was issued by CMS on March 30, 2007. Your request must be submitted to CMS **by DECEMBER 26, 2007** (180 days from the effective date of the regulation).

**PLEASE NOTE:** If an Organ Transplant Center does **not** submit a request for approval under the new Conditions of Participation **by DECEMBER 26, 2007**, CMS will conclude that the center no longer desires Medicare participation and will begin the process to withdraw Medicare approval.

**There is no application form.** Transplant centers must send a request (e.g. a letter) to CMS with specific information. For a list of all transplant centers covered by the regulation and a listing of the minimum information that must be included in all requests to CMS for approval of your transplant center, please visit our transplant web page at: [www.cms.hhs.gov/CertificationandCompliance/20\\_Transplant.asp](http://www.cms.hhs.gov/CertificationandCompliance/20_Transplant.asp). Transplant centers desiring first time Medicare certification must send a request to CMS with the same information. This can be done any time the center is ready for initial Medicare certification.

If you have any questions concerning the approval requests, timelines for the regulation, the information that must be submitted with the approval request, or the survey and certification process, please direct your inquiries to Sherry Clark in the Survey and Certification Group at CMS at (410) 786-8476.

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## An Interesting Article by One of CMS' Own

William D. Rogers, M.D., FACEP, Medical Officer in the Office of the Administrator Director at CMS, has written an article that invites all physicians to participate in PPAC, the Open Door Forum, and PRIT to help reduce Medicare's administrative burden. Please see the attached article to read more!



Medicare Patient  
Management Aug 200

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*I hope you enjoy a very pleasant weekend!*

*With best regards ~ Valerie*

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**August 27, 2007**

## **NPI: Data Dissemination to Begin Sept 4th & Important Medicare Claims Processing Information**

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

Health plans are progressing to transition to full NPI implementation. Be sure to stay informed about the steps you need to take to bill correctly and test your NPI with all of the health plans with whom you do business.

### **National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on September 4, 2007**

NPPES health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI Registry.
2. A downloadable file.

CMS has extended the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data. CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

CMS has posted several documents to help providers understand what the downloadable file will look like, including a "Read Me" file, Header File, and Code Value document for the downloadable file on the CMS NPI web page at

[http://www.cms.hhs.gov/NationalProvIdentStand/06a\\_DataDissemination.asp](http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp).

## ***Important Information for Medicare Providers***

### **Starting September 3, 2007, Medicare Carriers and DME MACs Will Begin Transitioning their Systems to Start Rejecting Claims when the NPI and Legacy Provider Identifier cannot be found on the Medicare Crosswalk**

Since May 29, 2007, Medicare Fiscal Intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating NPIs and Legacy Provider Identifier pairs submitted on claims against the Medicare NPI Crosswalk. Between the period of September 3, 2007 and October 29, 2007, all other Part B carriers and DME MACS will begin to turn on edits to validate the NPI/Legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Contractors have been instructed to inform providers at a minimum of 7 days prior to turning on the edits to validate the NPI/Legacy pairs against the Crosswalk.

If you are receiving informational edits today, we strongly urge you to validate that the NPPES has ALL of the NPI and legacy numbers you intend to use on claims and for billing purposes. If NPPES is correct, and you continue to receive information edits, you should ask your contractor to validate the provider information in their system. If the contractor information is not correct, you may be instructed to submit an enrollment form or CMS-855. Please include ALL of your NPI/Legacy numbers in NPPES AND all of your NPIs that are to be used in place of your legacy on the CMS-855. If the information is different in the two systems, there is a very good chance your claim will reject. NPPES data may be verified at <https://nppes.cms.hhs.gov> on the web.

### **Medicare Efforts to Minimize Rejections and Suspensions**

CMS CR5649, Transmittal number 1262 dated June 8, 2007, instructed Medicare Contractors to identify providers with the highest volume of rejections (or potential rejections/informational edits) due to invalid NPI information. They were also instructed to identify providers who are not submitting their NPI. Contractors have begun calling providers that fit these categories. If you are contacted, you may be asked to validate your NPPES information or confirm that the information in the Contractor's Provider file is correct. If you are not submitting your NPI at this time, your Contractor will ask: why you are not submitting it, the date you plan to submit it, and will ask you to send a small batch of claims using your NPI only, if possible.

Additionally, all Medicare providers could receive phone calls and/or letters from their contractors in the event that a claim suspends due to problems with mapping a provider's NPI to a legacy provider identifier. This could happen in the instance where one NPI is tied to several legacy identifiers. If it is determined that the claim suspended due to incorrect data in the Contractors provider file or NPPES, the provider will be requested to either update their information in NPPES and/or submit an updated CMS-855 form.

If the provider does not respond within 14 calendar days to this communication, the Contractor will return the claim as unprocessable. Conversely, if the provider does respond, it may furnish the Legacy number over the phone; however, the Contractor will ensure that it is in compliance with the Medicare Program Integrity Manual (Publication 100-08), chapter 10, section 17.2 regarding the release of information.

### **Reporting a Group Practice NPI on Claims**

Medicare has identified instances where the Multi-Carrier System (MCS) is correcting billing or pay-to provider data on Part B claims submitted by group practices. As of May 18, 2007, the MCS Part B claims processing systems no longer corrects claims submitted by group practices that are reporting the individual rendering Provider Identification Number (PIN) or individual rendering NPI in either the billing or pay-to provider identifier fields. Groups should enter either their group NPI or group NPI and legacy PIN number pair in either of these fields.

Medicare has also reported instances of incorrect billing occurring with DME MAC's. Providers must ensure that if they enumerate as individuals in the National Supplier Clearinghouse (NSC), they must enumerate as individuals in NPPES. If they enumerate as organizations in NSC, they should do the same in NPPES.

### **Update to 835 Remittance Advice Changes in MLN SE0725**

In MLN SE0725 Medicare described the 835 changes that would occur for the 835 Remittance Advice and that those changes would occur July 2, 2007 for DME MACS only. The article also went on to note that Medicare would notify providers when the Part A Institutional and Part B Professional 835 would be changing. Medicare 835 Electronic Remittance Advices will reflect the noted changes on Remittances for Part A and Part B, starting April 7, 2008.

### **Transcript for August 2<sup>nd</sup> Roundtable Now Available**

The transcript for the August 2nd, Medicare FFS Q&A Session: Common Billing Errors, Roundtable is now available at

[http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/aug\\_2\\_npi\\_transcript.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/aug_2_npi_transcript.pdf) on the CMS NPI page.

### **Reminder: Recent MLN Matters Articles**

Several recent Special Edition MLN Matters articles contain important billing information for Medicare providers and suppliers, including:

- How to use the NPI correctly on Part A and Part B claims  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>
- Information on use of the NPI on the new CMS 1500 and UB-04 Forms  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0729.pdf>

### **General Medicare Claims Processing Reminder**

Unrelated to the NPI, Fee-for-Service Medicare claims can be rejected by contractors for a variety of reasons including:

- incorrect billing information,
- the provider has been terminated from the program
- the beneficiary is not eligible for Medicare
- the claim was sent to the wrong contractor

If a provider has questions about a claim rejected by an FI/carrier or MAC, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary, who received the service billed on the claim, to the 1-800-Medicare toll free line to resolve a claim rejection.

## ***Still Confused?***

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page

[www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand) on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

***Nicole M. Cooney for Valerie Haugen***

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**August 28, 2007**

## **CMS Issues Final Rule Prohibiting Physician Self-Referral**

### **CMS ISSUES FINAL RULE PROHIBITING PHYSICIAN SELF-REFERRAL**

CMS today issued final regulations prohibiting physicians from referring Medicare patients for certain items, services and tests provided by businesses in which they or their immediate family members have a financial interest. This regulation is the third phase of the final regulations implementing the physician self-referral prohibition commonly referred to as the Stark law.

"These rules protect beneficiaries from receiving services they may not need *and* the Medicare program from paying potentially unnecessary costs," said Herb Kuhn, CMS acting deputy administrator.

This third phase of rulemaking (Phase III) responds to public comments on the Phase II interim final rule published March 26, 2004 in the *Federal Register*. The rule does not establish any new exceptions to the self-referral prohibition, but rather makes certain refinements that could permit or, in some cases, require restructuring of some existing arrangements, CMS officials explained.

The final rule, which was put on display Monday, will be published in the September 5, 2007 *Federal Register*. To view the rule, go to:

[http://www.cms.hhs.gov/PhysicianSelfReferral/04a\\_regphase3.asp](http://www.cms.hhs.gov/PhysicianSelfReferral/04a_regphase3.asp). For more information, visit the following link on the CMS website:  
<http://www.cms.hhs.gov/PhysicianSelfReferral/>.

To view the entire press release, please click here:  
[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

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**August 29, 2007**

## **Present on Admission Indicator for Hospital Claims**

Effective October 1, 2007, Medicare will begin to accept a Present On Admission (POA) Indicator for every diagnosis on inpatient acute care hospital claims; however, providers must submit the POA on hospital claims beginning with discharges on or after January 1, 2008. Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, psychiatric hospitals, inpatient rehabilitation facilities, and children's inpatient facilities are exempt from this requirement.

For more information on this POA requirement, please see MLN Matters Article #MM5499 which can be downloaded at the following url:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf>

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## **CMS Updates ASC Payment Information for Value-Driven Health Care**

### **CMS Updates Ambulatory Surgical Center Payment Information for Value-Driven Health Care (8-29-07)**

As part of his commitment to make health care more affordable and accessible, President Bush directed the U.S. Department of Health and Human Services to make cost and quality data available to all Americans. As a first step in this initiative, on June 1, 2006, Medicare posted information about the payments it made to hospitals in fiscal year 2005 for common elective procedures and other hospital admissions. Similar postings of Medicare payment data followed during the year for Ambulatory Surgery Centers (ASCs), Hospital Outpatient Departments, and Physician Services.

On June 20, 2007, Medicare updated last year's inpatient hospital data. Today, August 29, 2007, we are now presenting an update to last year's ASC data. The information is being displayed in the same format as last year, updated with calendar year (CY) 2006 data. The posting update may be found at:

<http://www.cms.hhs.gov/HealthCareConInit/>

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**August 31, 2007**

## **Your Friday Reading Materials**

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

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*Happy Labor Day weekend everyone! Once again, a wide range of topics this week, including information on:*

- **Initiative Regarding Fraudulent Infusion Therapy Providers**
- **September is National Cholesterol Education Month**
- **Beneficiary-Related News Regarding Medicare Part D**
- **Another Interesting Article By One of CMS' Own**

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### **Initiative Regarding Fraudulent Infusion Therapy Providers**

Health and Human Services Secretary (HHS) Mike Leavitt announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers there will be required to reapply to be a qualified Medicare infusion therapy provider.

“HHS continues to work with the Department of Justice (DOJ) to protect the public and Medicare by stopping fraud before it happens,” Secretary Leavitt said. “This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system.” The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership; have owners, partners, directors or managing employees who have committed a felony, or no longer meet each and every provider enrollment requirement will have their billing privileges revoked.

The DOJ is supporting HHS' new controls through a surge in prosecutions for health care fraud in South Florida. In May, the DOJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the



“phase one” Strike Force in Miami last March, DOJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than \$345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.

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### **September is National Cholesterol Education Month!**

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke. This benefit presents an excellent opportunity for health care professionals to help their eligible Medicare patients check their cholesterol status, know their risk for heart disease and the steps they can take toward following a heart-healthy lifestyle that can lower their risk for heart disease and keep it down.

Medicare provides cardiovascular screening blood tests for all asymptomatic beneficiaries every 5 years. The beneficiary must have no apparent signs or symptoms of cardiovascular disease. Covered screening tests include:

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

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

**IMPORTANT NOTE: The cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination also known as the “Welcome to Medicare” visit and does not have to be obtained within the first six months of a beneficiary’s Medicare Part B coverage.**

### **For More Information**

- For more information about Medicare’s coverage of cardiovascular screening blood tests, including coverage, coding, billing and reimbursement, please visit the following CMS website:
  - The MLN Preventive Services Educational Products Web Page  
[www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)



- For information to share with your Medicare patients, please visit [www.medicare.gov](http://www.medicare.gov)
- To learn more about National Cholesterol Education Month, please refer to the National Heart, Lung, and Blood Institute's 2007 National Cholesterol Education Month Kit <http://hp2010.nhlbi.nih.gov/cholmonth/>

Thank you for helping CMS ensure that all eligible people with Medicare take full advantage of this preventive screening service.

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### **Beneficiary-Related News Regarding Medicare Part D**

#### ***Part D - Guide to CMS, SSA and Plan Mailings -- Summer and Fall 2007***

The attached guide is a comprehensive summary of the mailings from CMS that are going out this year to Medicare beneficiaries relating to Part D. It also details actions a beneficiary should take as a result of these mailings and provides links to the notices that are currently available. Color coding within the document helps to provide a quick guide to what the beneficiary's circumstances are with respect to the Part D benefit. CMS had excellent feedback on the use of this document last year and we believe the information it contains will be particularly useful to staff that help Medicare beneficiaries enroll. We will also be working to set up some training over the next couple of months, including an Open Door Forum and a Satellite broadcast for an overview of the process and on enhancements to the plan finder for this year. More information on those activities will be coming soon.

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### **Another Interesting Article by One of CMS' Own**

William D. Rogers, M.D., FACEP, Medical Officer in the Office of the Administrator Director at CMS, shares his most recent thoughts regarding the National Provider Identifier (NPI). Read more in the attached article, which was recently published in Internal Medicine World Report.



Mailings 2007 - 8  
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*Please enjoy a safe and happy Labor Day!*

*With best regards ~ Valerie*

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