

Provider Partnership Program (PPP) E-mail Notification Archives

March 2, 2007

March is National Nutrition Month

March is National Nutrition Month® – Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. Approximately 8.6 million Americans¹ at least 60 years or older are diagnosed with diabetes or acute renal failure. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

Medicare Coverage

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis) when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement, or a “grandfathered” dietitian or nutritionist who was licensed or certified as of December 21, 2000. A referral by the beneficiary’s treating physician indicating a diagnosis of diabetes or renal disease is required. Medicare provides coverage for 3 hours of MNT in the first year and 2 hours in subsequent years.

What Can You Do?

As a trusted source of health care information, your patients rely on their physician’s or other health care professional’s recommendations. CMS requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For More Information

- For more information about Medicare’s coverage of MNT services, visit the CMS website <http://www.cms.hhs.gov/MedicalNutritionTherapy/>
- CMS has also developed a variety of educational products and resources to help health care professionals and their staffs become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
 - The MLN Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.
 - The CMS website provides information for each preventive service covered by Medicare. Go to www.cms.hhs.gov, select “Medicare” and scroll down to the “Prevention” heading.

¹ The United States Renal Data System and National Diabetes Information Clearinghouse; <http://diabetes.niddk.nih.gov/dm/pubs/statistics>.

- For information to share with your Medicare patients, visit www.medicare.gov on the Web.
- For more information about National Nutrition Month®, please visit <http://www.eatright.org>.

¹ The United States Renal Data System and National Diabetes Information Clearinghouse;
<http://diabetes.niddk.nih.gov/dm/pubs/statistics>.

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Your Friday Reading Materials

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

Happy Friday and Happy March to everyone! This week's news items include information on:

- **Commenting on a Revised Advance Beneficiary Notice (ABN)**
- **Use of the UB-04 and UB-92**
- **Listening Session #2 on Design Issues for the Medicare Hospital Value-Based Purchasing Plan**
- **The Medicare Contractor Provider Satisfaction Survey**

Commenting on a Revised Advance Beneficiary Notice

A notice was published in the Federal Register on February 23, 2007 on a revised version of the general ABN (CMS-R-131). Public comments are requested during the 60-day comment period and will be considered as part of finalizing the revised ABN.

As required by Section 1879 of the Social Security Act, the ABN is used to inform beneficiaries of potential financial liability, except in home health care and inpatient

hospital settings. Formerly, CMS maintained two versions of the ABN, a general and lab-test specific version, but with this revision, CMS proposes to combine these two versions of the ABN into a single notice meeting both needs. Other proposed changes are described in the website posting. Physicians, practitioners, providers and suppliers already required to use ABNs will continue to use the currently approved ABN until the revised notice is finalized and approved.

To view the announcement and requirements for submitting comments in the Federal Register, go to:

<http://www.gpoaccess.gov/fr/advanced.html>

On this page, under “Search by Issue Date”, on the “Specific Date”: line, select “On” and enter “02/23/2007” in the date field. After “Search:” in the next line, enter “CMS-R-131”. The announcement should appear first if multiple items are found.

To obtain copies of the ABN and supporting documents, go to:

<http://www.cms.hhs.gov/PaperworkReductionActof1995>.

On the menu on the left side of this page, click on “PRA Listing”, then scroll down or search for “CMS-R-131”. Alternatively, you may email your request including your name, address, phone number, OMB control number (0938-0566) and CMS document identifier (CMS-R-131) to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

[Note both sites may be down briefly. Please try multiple times if you encounter a problem.]

In order to be accepted, comments must be sent to:

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development – C
Attention: Bonnie L. Harkless
Room C4-26-05,
7500 Security Blvd.
Baltimore, Maryland 21244-1850

These comments must be received by 5 p.m. on April 24, 2007.

Use of the UB-04 and UB-92

Discussion on the web page below addresses the issue raised during the open Q&A portion on the February 15, 2007 Skilled Nursing Facility-Long Term Care Open Door Forum regarding use of the UB-04 and UB-92 prior to

the date the UB-92 will no longer be accepted by CMS (after May 22, 2007).

Please see:

http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Listening Session #2 on Design Issues for the Medicare Hospital Value-Based Purchasing Plan

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of the Federal Register Notice for Listening Session #2 that is part of the development of the Medicare Hospital Value-Based Purchasing Plan authorized by Section 5001(b) of the Deficit Reduction Act of 2005. The purpose of this Listening Session is to solicit comments on the Draft Plan for Medicare Hospital Value-Based Purchasing. The Draft Plan will be posted on Thursday, March 22, 2007 on the CMS website, Hospital Center, under Spotlights at:

<http://www.cms.hhs.gov/center/hospital.asp>.

CMS will conduct Listening Session #2 on Thursday, April 12, 2007 from 10 AM to 5 PM in the CMS Baltimore auditorium. Attendees will have the opportunity to present verbal comments on the draft Plan. A dial-in number will be provided for those who cannot attend, and limited time will be allocated for comments from telephone participants.

All interested parties are encouraged to participate in the Listening Session, including, but not limited to hospitals and other health care providers, purchasers, employers, consumers, and representatives of these stakeholders. Registration is required for both on-site and teleconference participation. Registration information is available at: <http://registration.intercall.com/go/cms2>. Confirmation of registration is provided. Registration closes Monday, April 9, 2007 at 5:00 PM EDT.

Written comments on the draft Medicare Hospital Value-Based Purchasing Plan will be accepted until April 19, 2007 at 5:00 PM EDT and may be sent by e-mail to cmshospitalVBP@cms.hhs.gov. Comments may also be sent by FAX to 410-786-0330 or mailed to Robin Phillips, Medicare Feedback Group, Centers for Medicare & Medicaid Services, Mail Stop C4-13-07, 7500 Security Blvd., Baltimore, MD 21244-1850.

For more information about the Listening Session, please view the Federal Register Notice (CMS-1383-N2) at

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-3048.pdf>

Medicare Contractor Provider Satisfaction Survey (MCPSS)

The Centers for Medicare & Medicaid Services (CMS) will administer its annual Medicare Contractor Provider Satisfaction Survey (MCPSS) in January 2008. The MCPSS is designed to measure provider satisfaction with and perceptions about the services provided by Medicare Fee-for-Service (FFS) claims-payment contractors. The survey gives providers the opportunity to rate their Contractor(s) on seven business functions: provider outreach and education, provider

inquiries, claims processing, appeals, medical review, provider enrollment, and provider reimbursement.

CMS has requested clearance from the Office of Management and Budget (OMB) for the administration of the 2008 MCPSS. The reasons for this OMB submission is to 1) increase sample size, 2) make some minor changes to the survey instrument, and 3) address research and development activities needed to continuously improve the study. To obtain copies of the supporting statement and any related forms, you may access CMS' Paperwork Reduction Act website at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, select PRA Listing and view CMS Form Number CMS-10097, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

Comments and recommendations for this collection of information must be received at the address below, no later than 5 p.m. on **April 24, 2007**:

CMS, Office of Strategic
Operations and Regulatory Affairs
Division of Regulations Development—C
Attention: Bonnie L Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850.

For additional information about the MCPSS, please visit: <http://www.cms.hhs.gov/mcps/>.

Flu Shot Reminder – It's Not Too Late to Give and Get the Flu Shot! The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>

Hope you all enjoy your weekend ~ Valerie

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March 9, 2007

Incorrectly Formatted Versions of the Revised Form CMS-1500

Important Notice Regarding the Revised Form CMS-1500

In July 2006, the Form CMS-1500 (12-90) was revised by the National Uniform Claim Committee (NUCC) predominantly for the purpose of accommodating the National Provider Identifier. Since that time, the industry has been preparing for the implementation of the revised Form CMS-1500 (08-05). In September 2006, Medicare announced that it would implement the revised Form CMS-1500 (08-05) on January 1, 2007 with dual acceptability of both versions until March 31, 2007. Medicare further announced that beginning April 1, 2007, the only acceptable version of the form would be the Form CMS-1500 (08-05) and that the prior version, Form CMS-1500 (12-90), would be rejected.

It has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives which do not comply with the form specifications.

Given the circumstances, ***CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline*** while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date. In addition, during the interim contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to you, we are able to make you aware of the situation which will allow you to begin communications with your form supplier.

The following will help you to properly identify which form is which. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Questions may be directed to Brian Reitz at Brian.Reitz@cms.hhs.gov .

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Additional Preventive Service Coverage

New in 2007 ~ Medicare Now Provides Coverage for a One-time Ultrasound Screening for Abdominal Aortic Aneurysms as Part of the Initial Preventive Physical Examination

The Centers for Medicare & Medicaid Services (CMS) invites you to join with us in promoting awareness of abdominal aortic aneurysms (AAA) and the new screening benefit for the early detection of this disease. Three in four aortic aneurysms are AAAs. Aortic aneurysms account for about 15,000 deaths in the United States annually; of these 9,000 are AAA-related. Men are 5 to 10 times more likely than women to have an AAA and the risk increases with age. Although AAAs may be asymptomatic for years, as many as 1 in 3 eventually rupture if left untreated.^{[i] [iii]} Early diagnosis allows for more effective treatment and cure. Diagnosis of an AAA can be done painlessly with a simple ultrasound scan. Medicare now provides coverage for this screening service for eligible beneficiaries.

Medicare Coverage ~ Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their initial preventive physical examination (IPPE) also referred to as the Welcome to Medicare physical exam. There is no Part B deductible. The coinsurance/copayment applies.

IMPORTANT NOTE: Only Medicare beneficiaries who receive a referral for the AAA ultrasound screening as part of the Welcome to Medicare physical exam will be covered for the AAA benefit.

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing the use of preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their Welcome to Medicare physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the ultrasound screening as part of their Welcome to Medicare physical exam. It could save their lives!

For More Information

- For more information about Medicare's coverage of the AAA benefit, refer to *MLN Matters* article MM5235 (2006), *Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination*, located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf> on the CMS website.

- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
 - The MLN Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.
- For information to share with your Medicare patients, visit www.medicare.gov on the Web.
- For more information about Abdominal Aortic Aneurysms, please visit http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html on the Web.

Thank you for helping CMS to increase awareness of abdominal aortic aneurysm disease and the new AAA preventive benefit.

National Heart Lung and Blood Institute Diseases and Conditions Index;

http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html

^[ii] U.S. Preventive Services Task Force Screening for Abdominal Aortic Aneurysm: A Best Evidence Systematic Review
<http://www.ahrq.gov/clinic/uspstf05/aaascr/aaarev.htm>

I hope everyone enjoys a great weekend ~ Valerie

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March 13, 2007

New From the Medicare Learning Network

Two new items from the Medicare Learning Network  that just couldn't wait until Friday ~

2007 Physician Quality Reporting Initiative

A new *MLN Matters* article with important information on the **2007 Physician Quality Reporting Initiative (PQRI)** is now posted on the CMS website. This article will be helpful to Medicare physicians and other eligible providers interested in participating in the PQRI. You can view the article at <http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf> on the CMS website.

Rural Health Information

The *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* (Second Edition), which contains rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005, is now available in downloadable format on the Medicare Learning Network Publications Page located at www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.

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March 19, 2007

The Latest on the Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services (CMS) now has over 50 Frequently Asked Questions (FAQ) about the Physician Quality Reporting Initiative (PQRI) available on its website! You can access these FAQs by visiting the PQRI webpage at www.cms.hhs.gov/PQRI, on the CMS website. Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Questions" link.

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A Few Monday Items

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

Hello everyone ~ should be a good week what with spring coming and all. Today's news items include information on:

- **Medicare Preventive Services**
- **Beneficiary Related Information on the Medicare Prescription Drug Program and My Health, My Medicare**

Medicare Preventive Services

March is National Colorectal Cancer Awareness Month. Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare. Colorectal cancer is largely preventable through screening, which can find colon growths called polyps that can be removed before they turn into cancer. Screening can also detect cancer early when it is easier to treat and cure.

Screening for colorectal cancer is recommended for all adults ages 50 and older, although screening may start at younger ages for individuals who are at high risk for colon cancer. The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test that is used.

An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

In addition, risk for colorectal cancer increases with age. It is important to encourage patients who were screened before entering Medicare to continue with screening at clinically appropriate intervals.

Medicare Covers Screening Tests

Medicare covers the following screening tests to detect colorectal cancer early, when it is most treatable, and to identify people at high risk for developing this type of cancer:

- Fecal Occult Blood Test (FOBT)—Medicare covers both guaiac and immunoassay tests, but Medicare will only pay for one FOBT each year
- Colonoscopy—Medicare covers every 10 years for normal risk; more frequently for high risk persons
- Sigmoidoscopy—Medicare covers every 4 years
- Barium Enema—Medicare covers every 4 years for normal risk; every 2 years for high risk

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to Special Edition *MLN Matters* article:

SE0710 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf> .

New Coverage Information for 2007!

Starting in January 2007, Medicare waived the requirement that beneficiaries meet the deductible for **screening** colonoscopy, sigmoidoscopy, or barium enema (as an alternative to colonoscopy or sigmoidoscopy). In addition, the coinsurance for colonoscopy and sigmoidoscopy is now 25% when performed in ambulatory surgical centers and non-outpatient prospective payment system hospital outpatient departments.

For specific details about these changes, click on the following links:

- Special Edition *MLN Matters* article MM5387 (coinsurance changes)
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf>
- Special Edition *MLN Matters* article MM5127 (deductible change)
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf>

CMS Needs Your Help

CMS needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For information and resources to help you discuss colorectal cancer screening with your patients, visit the following American Cancer Society website:

http://www.cancer.org/colonmd?utm_source=CMSlistserv&utm_medium=email&utm_term=colon&utm_content=colonMD

Thank you for supporting CMS' effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

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Two Special Edition *MLN Matters* articles **SE0709** and **SE0711** are now posted to the CMS website that remind health care professionals about the coverage criteria and billing procedures for the following Medicare preventive benefits: prostate cancer screening services, the initial preventive physical examination (“Welcome to Medicare” Physical Exam), and ultrasound screening for abdominal aortic aneurysms.

SE0709, Reminder – Medicare Provides Coverage of Prostate Cancer Screening for Eligible Medicare Beneficiaries

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0709.pdf>

SE0711, Reminder – Medicare Now Provides Coverage for Eligible Medicare Beneficiaries of a One-Time Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) When Referred for this Screening as a Result of the Initial Preventive Physical Examination (“Welcome to Medicare” Physical Exam)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0711.pdf>

Beneficiary-Related News

CMS has revised the auto-enrollment letter for beneficiaries, with a copy of this letter posted on the CMS Partnership Website at

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

The purpose of the auto-enrollment notice is to inform people with Medicare and full Medicaid coverage about the change in their drug coverage from Medicaid to Medicare. The notice explains that these individuals will be enrolled in a Medicare Prescription Drug Plan if they haven’t joined a plan on their own, what plan Medicare will enroll them in, and their costs in the plan. It will also notify them that their Medicaid isn’t creditable prescription drug coverage. The notice includes a one-page letter printed on yellow paper, on one page (front and back) of questions and answers about Medicare prescription drug coverage.

The instruction memo to the plans is posted at

<http://www.cms.hhs.gov/partnerships/downloads/AENotice20070313.pdf>

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The next presentation in the **My Health, My Medicare** series of audio-conference training sessions sponsored by the Centers for Medicare & Medicaid Services (CMS) will be held:

When: Tuesday, March 20, 2007

Time: 12:30 – 1:30 p.m. EDT

Topics:

* New enhancements to MyMedicare.gov

- * Part D Special Enrollment Periods for people who lose or gain eligibility for the extra help in 2007
- * Part D premium withholding from Social Security benefits for people with other premium payers

Policy experts, including those who presented information on the new Limited Open Enrollment Period on the February 21 call, will be available to answer questions.

Call-in procedures:

Dial Toll free: 877-918-1351 (Please call in 15 minutes before the session begins.)

Pass code: NMTP

- You may download the PowerPoint slides for this session on the morning of the call. A live link to the slides will be provided with the reminder notice.
- Questions or problems? Please email NMTP@cms.hhs.gov

TTY Communications Relay Services are available for people who are hearing impaired.

Dial 7-1-1 or 1-800-855-2880, and for Internet Relay services click here

<<http://www.consumer.att.com/relay/which/index.html>>. A Relay Communications Assistant will help.

Archive of past calls

Previous training calls are posted on our home page within a week of the live presentation.

Please note: recordings are temporarily unavailable while the CMS web server is being updated.

Visit <http://www.cms.hhs.gov/NationalMedicareTrainingProgram>

- Use the menu on the left,
- Click on the Audio-Conference Training
<http://www.cms.hhs.gov/NationalMedicareTrainProg/10_Audio-Conference%20Training.asp> link, and
- Scroll to bottom of page.

Downloads section contains PowerPoint presentations and handouts.

Related Links Inside CMS section contains audio recordings.

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

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<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf> .

With best regards ~ Valerie

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March 21, 2007

Physician Quality Reporting Initiative Update

[Revised Physician Quality Reporting Initiative \(PQRI\) PowerPoint Presentation - Module One](#)

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a revised version of the 2007 Physician Quality Reporting Initiative (PQRI) Module One PowerPoint presentation has been posted to the CMS website. Updates have been made to the presentation and speaker's notes have been added to assist in the explanation and understanding of the training module.

To access the presentation, visit www.cms.hhs.gov/PQRI on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "Physician Quality Reporting Initiative PowerPoint Module One" link.

We would also like to remind you that Frequently Asked Questions (FAQ) about the PQRI are now available on the CMS website. As new FAQs are added regularly, you may want to check this site often. You can access these FAQs by visiting the PQRI webpage at www.cms.hhs.gov/PQRI, on the CMS website. Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Questions" link.

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2007 PQRI National Provider Conference Call

2007 Physician Quality Reporting Initiative (PQRI) National Provider Conference Call with Question & Answer Session

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the first in a series of national provider conference calls on the 2007 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:00 p.m. – 5:00 p.m., EST, on Tuesday, March 27, 2007.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). TRHCA section 101 authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who chose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5% of their charges during that period, subject to a cap. To review the list of eligible professionals, visit http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage on the CMS website. All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

An overview of the 2007 PQRI will be presented that will include discussion about eligible professionals, reporting, measures and codes, and analysis and payment. A PowerPoint slide presentation will be posted to the PQRI webpage at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage on the CMS website for you to download prior to the call so that you can follow along with the presenter, Susan Nedza, M.D.

In addition, *MLN Matters* article MM5558, posted on the Medicare Learning Network, can be referenced prior to the call. The article provides a program overview of the 2007 PQRI. MM5558 is available at the following link: <http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf>.

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

Conference call details:

Date: Tuesday, March 27, 2007

Conference Title: 2007 Physician Quality Reporting Initiative

Time: 3:00 p.m. – 5:00 p.m. EST

In order to receive the call-in information, you must register for the call via the internet by following the instructions below.

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.

1. To register for the call participants need to go to:
https://ww4.premconf.com/webrsvp/register?conf_id=549030
2. Click "Continue" to be taken to the registration screen.
3. Fill in all required data.
4. Click "Submit".
5. You will be taken to the confirmation screen where the call-in number will be given.
6. The pass code for the call is 549030.
7. To view the time the call will start, registrants will need to select their time zone in the drop down box under "Time" on the confirmation screen.
8. Click "Confirm Registration" to receive a confirmation email.

Online Evaluation Form

CMS has developed an online evaluation form that can be quickly completed and submitted. Participants are asked to complete this online evaluation form to help CMS make informed decisions on improving training activities. The online evaluation form titled "Training Evaluation Form" can be found on the registration page, http://www.cms.hhs.gov/medlearn/cont_eval_form.asp. CMS looks forward to hearing your comments.

If you have questions, or require special accommodations, please contact Geanelle E. Griffith at geanelle.griffith@cms.hhs.gov or at (410) 786-4466.

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March 22, 2007

2007 PQRI National Provider Conference Call

We are resending this message to correct the Internet link for conference call registration.
Per the revised message below, the correct URL to register is
https://ww4.premconf.com/webrsvp/register?conf_id=6342225.

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the first in a series of national provider conference calls on the 2007 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:00 p.m. – 5:00 p.m., EST, on Tuesday, March 27, 2007.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). TRHCA section 101 authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who chose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5% of their charges during that period, subject to a cap. To review the list of eligible professionals, visit http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage on the CMS website. All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

An overview of the 2007 PQRI will be presented that will include discussion about eligible professionals, reporting, measures and codes, and analysis and payment. A PowerPoint slide presentation will be posted to the PQRI webpage at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage on the CMS website for you to download prior to the call so that you can follow along with the presenter, Susan Nedza, M.D.

In addition, *MLN Matters* article MM5558, posted on the Medicare Learning Network, can be referenced prior to the call. The article provides a program overview of the 2007 PQRI. MM5558 is available at the following link: <http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf>.

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

Conference call details:

Date: Tuesday, March 27,

2007

Conference Title:

2007 Physician Quality Reporting Initiative

Time: 3:00 p.m. – 5:00 p.m. EST

In order to receive the call-in information, you must register for the call via the internet by following the instructions below.

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.

1. To register for the call participants need to go to:
https://ww4.premconf.com/webrsvp/register?conf_id=6342225
2. Click "Continue" to be taken to the registration screen.
3. Fill in all required data.
4. Click "Submit".
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6. The pass code for the call is 549030.
7. To view the time the call will start, registrants will need to select their time zone in the drop down box under "Time" on the confirmation screen.
8. Click "Confirm Registration" to receive a confirmation email.

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CMS has developed an online evaluation form that can be quickly completed and submitted. Participants are asked to complete this online evaluation form to help CMS make informed decisions on improving training activities. The online evaluation form titled "Training Evaluation Form" can be found on the registration page, http://www.cms.hhs.gov/medlearn/cont_eval_form.asp. CMS looks forward to hearing your comments.

If you have questions, or require special accommodations, please contact Geanelle E. Griffith at geanelle.griffith@cms.hhs.gov or at (410) 786-4466.

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March 23, 2007

Important News About the Medicare DMEPOS Competitive Bidding Program

ANNOUNCEMENT OF THE DMEPOS COMPETITIVE BIDDING IMPLEMENTATION CONTRACTOR WEBSITE

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the newly established Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Implementation Contractor (CBIC) website. CMS has contracted with Palmetto GBA, the CBIC, to conduct certain functions relating to the administration of the DMEPOS Competitive Bidding Program. These functions include: preparing the request for bids (RFB), performing bid evaluations, and ensuring that suppliers meet all applicable financial and quality standards. In addition, Palmetto GBA will support CMS efforts to conduct an education program for beneficiaries, suppliers and referral agents. Palmetto GBA also assists CMS and its contractors in monitoring the program's effectiveness, access and quality. This website will contain important and up-to-date information on the Medicare DMEPOS Competitive Bidding Program. To gain access to the CBIC Website, go to the Competitive Acquisition for DMEPOS Overview web page at http://www.cms.hhs.gov/competitiveacqfordmepos/01_overview.asp?. Once there, scroll down to "Related Links Outside CMS" and click on the link to "Contractor (CBIC) Web site".

NOTICE TO ALL SUPPLIERS INTERESTED IN COMPETITIVE BIDDING

To ensure the safety and security of all suppliers interested in participating in the Competitive Bidding Program, all suppliers will have to be authenticated before you will be able to submit a bid. It is imperative that all information that you have provided to the National Supplier Clearinghouse (NSC) is up-to-date for successful authentication to occur. If you have not updated your NSC information, or if you are unsure if the information is correct, please contact the NSC.

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Your Friday Reading Materials

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

Hello everyone and Happy Spring! Things have really been hopping around here this week, so there are several items included in today's note (in addition to the messages I've been sending to you throughout the week), including information on:

• **National Provider Identifier (including important information to Medicare providers regarding use of the CMS Form-1500)**



- **Updates from the Medicare Learning Network**
- **New Medicare Hospital Conditions of Participation for Transplant Centers**
- **Medicare Administrative Contractor Procurements**
- **April Average Sales Price Updates**
- **Additional Physician Election Period for CAP**
- **Colorectal Cancer Awareness Month Message**
- **Options Paper for Medicare Hospital Value-Based Purchasing Listening Session**

NPI – Will You Be Ready?

GET IT.

The compliance date, May 23, 2007, is only **2 months** away. Covered health care providers have had 22 months to apply for their NPI – further procrastination could disrupt your cash flow. Act **now** if you still don't have your NPI! **It's easy and it's free!**

SHARE IT.

Have your NPI and don't know what to do with it? Share it. Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g., those who bill for ordered or referred services). You should also share it with your business associates, such as a billing service, vendor, or clearinghouse. Pay attention to information from health plans with which you do business as to when they will begin accepting the NPI in claims and other standard transactions.

USE IT.

Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Revisions to the NPPES Website

We are revising some of the language on the NPPES NPI Application Help page that relates to the selection of the Entity Type. Among other changes, our revision will remove a reference to “atypical services.” This reference is being removed because entities who furnish only “atypical services” are not eligible to apply for NPIs.

NPI Disclosures by Industry Entities to Industry Entities

A new guidance document is available at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIdisclosures.pdf> on the CMS NPI web page. This guidance relates to the disclosure of health care providers' NPIs by health industry entities for the purpose of using NPIs in HIPAA standard transactions.

New Frequently Asked Questions (FAQs) Posted

CMS has posted new NPI FAQs on its website.

Questions include:

- I have been told to protect my National provider Identifier (NPI) and I have been told to share my NPI - How am I to protect my NPI if I must share it with others?
- [With whom should I share my NPI?](#)
- Am I required to share my NPI with health plans, other providers and any other entity that requests it?
- Does the National Plan and Provider Enumeration System (NPPES) handle applications for health plan identifiers, as it does for health care provider identifiers?
- May a health plan require that an individual health care provider obtain two NPIs if that provider has two separate business roles – for example, as a physician seeing patients at a group practice, and as a durable medical equipment (DME) supplier?

To view these FAQs, please go to the CMS dedicated NPI web page at <http://www.cms.hhs.gov/NationalProvIdentStand/> and click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated".

Important Information for Medicare Providers

Reminder to Use the NPI and Legacy Identifiers on Medicare Claims

Medicare is accepting the NPI on claims; however, providers should also submit their Medicare legacy identifiers on their claims until further instructions are released.

Important Notice: Medicare Extends Date for Accepting Form CMS-1500 (12-90)

While Medicare began to accept the revised Form CMS-1500 (08-05) on January 1, 2007 and was positioned to completely cutover to the new form on April 1, 2007, it has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives which do not comply with the form specifications. However, not all of the new forms are in error.

Given the circumstances, **CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date.** In addition, during the interim contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to providers, we are able to make them aware of the situation so they can begin communications with their form suppliers.

The following will help to properly identify whether their version of the form needs to be updated. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. Checking the information at the upper right hand corner of the form is the best way to identify if that particular version is correct. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Upcoming WEDI Events

WEDI will host the 16th Annual WEDI National Conference May 14 – 17 in Baltimore, Maryland. Visit the WEDI website for more details on this event, as well as others, at <http://www.wedi.org/npioi/index.shtml> on the web. Please note that there is a charge to participate in WEDI events.

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 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.



MLN Matters Articles Search Feature Now working - A full-text search is now available for ALL MLN Matters Articles via the search link located at the top of the 2004, '05, '06, and '07 pages at <http://www.cms.hhs.gov/MLNMattersArticles/>. This enables users to search title, text, and body for any article needed, even if you only have the topic or general subject to start with. Give it a try!

Recently Released MLN Matters Articles:

NEW: MM5568 – Extension for Acceptance of Form CMS-1500 (12-90)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5568.pdf>

Provider Types Affected: Physicians, non physician practitioners and suppliers who submit claims for their services using the Form CMS-1500 to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)). **Be aware that some of the new Form CMS-1500 (08-05) forms have been printed incorrectly. This article contains details on this issue.**

Revised: MM5391 – Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (Version 8/05)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5391.pdf>

Provider Types Affected: Physicians and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

**NEW MEDICARE HOSPITAL CONDITIONS OF PARTICIPATION
FOR TRANSPLANT CENTERS**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule setting forth the requirements that transplant centers must meet to participate in the Medicare program that moves Medicare covered transplant programs toward an outcome-focused system.

This final rule will move Medicare-covered transplant programs toward an outcome-focused system that reflects the clinical experience, resources and commitment of the transplant program. The rule contains comprehensive conditions of participation for transplant programs serving Medicare beneficiaries.

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

To view the Conditions of Participation Transplant Final Rule:
<http://www.cms.hhs.gov/CFCsAndCoPs/>

Planned Release of the Scope of Work and Unique Requirements that CMS Will Include in the Next Medicare Administrative Contractor (MAC) Procurements

CMS announced on July 31, 2006 the awarding of the first of 15 contracts for the combined administration of Part A and Part B claims activities in a multi-state jurisdiction. That first Medicare Administrative Contractor (MAC) award was for the 6-state jurisdiction of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming (Jurisdiction 3). Currently, CMS is in the process of evaluating proposals for seven of the A/B MAC jurisdictions under Cycle One, accounting for approximately 45 percent of the Part A/Part B fee-for-service claims workload.

CMS has seven more Part A/Part B MAC contracts to acquire through the competitive process. The Cycle Two procurements will be conducted in two rounds, accounting for approximately 46 percent of the Part A/Part B fee-for-service claims workload.

On Monday, January 22, 2007 CMS published on the Federal Business Opportunities website (www.FedBizOpps.gov) a Request for Information (RFI) detailing the jurisdictional breakouts and the proposed integration of the home health and hospice jurisdictional claims workloads into four of the seven jurisdictions to be competed in the first round of competitions under Cycle Two.

The four A/B MAC and corresponding home health jurisdictions in round one are:

- J6 (Illinois, Minnesota, and Wisconsin) and Home Health / Hospice Jurisdiction D
- J11 (North Carolina, South Carolina, Virginia and West Virginia) and Home Health / Hospice Jurisdiction C
- J14 (Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) and Home Health / Hospice Jurisdiction A
- J15 (Kentucky and Ohio) and Home Health / Hospice Jurisdiction B

The Request for Proposal for this first round of competitions under Cycle Two will include the following jurisdiction specific requirements:

- Medicare Part B Drug Code Crosswalk File for J11
- Home Health Third Party Liability Demonstration Project for J14
- Medical Adult Day Care Demonstration for J11, J14, J15
- Low Vision Demonstration for J11 & J14

On March 22, 2007 a Request for Information (RFI) containing the planned Statement Of Work (SOW) will be published on the Federal Business Opportunities website (www.FedBizOpps.gov). CMS encourages everyone to review the RFI at FedBizOpps, or via a link on the CMS Medicare Contracting Reform website (<http://www.cms.hhs.gov/MedicareContractingReform/>), and provide comments or questions. You will find guidance on how/where to submit comments and questions

about the RFI on the FedBizOpps website. The comment period closes on April 6, 2007.

To learn more about the transition to the A/B MAC environment, please visit the Medicare Contracting Reform website at:
www.cms.hhs.gov/MedicareContractingReform.

April Average Sales Price Updates

The Centers for Medicare & Medicaid Services (CMS) has made available the Medicare Part B Drug and Biological Average Sales Price (ASP) Payment Amounts for April 1 to June 30, 2007 on the CMS website at
http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage
The files are located in the "Downloads" section of the web page.

Additional Physician Election Period for CAP

An additional election period for physicians who are not currently participating in the CAP has been announced. The CAP is an alternative to the Average Sales Price (ASP) method of acquiring many drugs and biologicals administered incident to a physician's services.

The additional election period will begin on **May 1, 2007 and end June 15, 2007**. Effective dates for physicians who elect to participate during this period will be from August 1, 2007 through December 31, 2007. Please note that this physician election period is only for new CAP elections. It is not necessary to renew CAP election at this time. Requests for termination from the program will not be accepted during this election period.

Additional information about the CAP physician election process is at
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage .
Additional information about the CAP is available at
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp#TopOfPage .
The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage .

Completed and signed physician election forms should be returned by mail to your local carrier-the carrier that processes your Part B drug claims after May 1, 2007. Please do not return the completed forms to CMS. In order to qualify for a CAP effective date of August 1, 2007, election forms for the additional election period must be postmarked no later than June 15, 2007.

Are You and Your Staff Ready?

March is National Colorectal Cancer Awareness Month. Is your practice or office organized to make sure that your patients are screened for colorectal cancer and get the appropriate follow-up? Several resources are available to help practitioners and their office staff to improve their practices – including delivery of colorectal cancer screening, referrals for screening, care transitions, and follow-up.

The American Cancer Society and the National Colorectal Cancer Roundtable developed a guide titled, ***What You Should Know about Screening for Colorectal Cancer: A Primary Care Clinician’s Evidence-Based Toolbox and Guide***. The guide is designed to help clinicians improve office practices to support colorectal cancer screening. This resource is available at the following link:

http://www.cancer.org/docroot/PRO/content/PRO_4_1x_ColonMD_Clinicians_Manual.pdf.asp?utm_source=CMSlistserves&utm_medium=email&utm_term=Colon&utm_content=ColonMD%2BManual

The American Cancer Society has developed materials to help support practitioners in discussing colorectal cancer screening with their patients. These resources include reminder letters, phone reminder scripts, brochures, and wall charts, and are available for downloading or ordering at the following link:

http://www.cancer.org/docroot/PRO/PRO_4_2_ColonMD_Educating_Patients.asp?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=ColonMDEducatingPatients

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to Special Edition *MLN Matters* article SE0710

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf>

Thank you for supporting CMS’ effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

Posting of the Options Paper for Listening Session on Medicare Hospital Value-Based Purchasing – April 12, 2007

The Centers for Medicare & Medicaid Services (CMS) is pleased to present the Options Paper that addresses the proposed Performance Assessment Model and other features of

Medicare Hospital Value-Based Purchasing being developed under Section 5001(b) of the Deficit Reduction Act of 2005. The Options Paper is posted on the CMS website, Hospital Center, under Spotlights at <http://www.cms.hhs.gov/center/hospital.asp>.

CMS will conduct a Listening Session on April 12, 2007 focused on this Options Paper. The Listening Session will be held from 10 AM to 5 PM in the CMS Baltimore auditorium. All interested parties are encouraged to participate, including, but not limited to, hospitals and other health care providers, purchasers, employers, consumers, and representatives of these stakeholders. Registration is required for both on-site and teleconference participation. Attendees and telephone participants will have the opportunity to present questions and comments. Registration information is available at: <http://registration.intercall.com/go/cms2>. Confirmation of registration is provided.

The agenda and PowerPoint slide presentations for the Listening Session will be posted on the Hospital Center web page by COB on Friday, April 6th. An audio podcast of the Listening Session will be posted by COB on Monday, April 16th.

Written comments on the Options Paper will be accepted until April 19th at 5 PM EDT and may be sent by e-mail to cmshospitalVBP@cms.hhs.gov. Comments may also be sent by FAX to 410-786-0330 or mailed to Robin Phillips, Medicare Feedback Group, Centers for Medicare & Medicaid Services, Mail Stop C4-13-07, 7500 Security Blvd., Baltimore, MD 21244-1850.

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

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: <http://www.cms.hhs.gov/MLNMMattersArticles/downloads/SE0667.pdf>

I sincerely hope you all enjoy this first Spring weekend!

With best regards ~ Valerie

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March 26, 2007

Materials for 3/27/07 National Provider Call on the 2007 Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) will be posting a new PowerPoint presentation that will be used on the March 27, 2007 National Provider Conference Call on the 2007 Physician Quality Reporting Initiative (PQRI).

To access the presentation, visit www.cms.hhs.gov/PQRI on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section and click on the “Physician Quality Reporting Initiative National Provider Call” link.

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Materials for 3/27/07 National Provider Call on the 2007 Physician Quality Reporting Initiative

This message is being resent to include additional details.

The Centers for Medicare & Medicaid Services (CMS) will be posting a new PowerPoint presentation that will be used on the March 27, 2007 National Provider

Conference Call on the 2007 Physician Quality Reporting Initiative (PQRI). The new presentation is titled, “Physician Quality Reporting Initiative – National Provider Call – March 27, 2007.

To access the presentation, visit www.cms.hhs.gov/PQRI on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section and click on the “PQRI - National Provider Call, March 27, 2007” link. Please check this page and download the presentation on the morning of March 27th to ensure you have the most recent version.

Thank you.

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March 27, 2007

New CMS Website for Contract & Enrollment Data on MA and Part D Plans

The Centers for Medicare & Medicaid Services (CMS) announces the launch of the new section on the CMS public website to house contract and enrollment data about MA and Part D plans. The site can be found at:
<http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>

This site provides: a) a plan directory, and b) an MA claims processing contact directory. These directories contain basic information about the contract as well as contact information for the plan itself. CMS will update these directories on a monthly basis. Also, CMS is providing these data in three formats: a PDF document sorted by contract name, a PDF document sorted by contract number, and an Excel version.

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March 28, 2007

A Mid-Week Colorectal Cancer Screening Message

Interested in seeing how well your county or state has done in providing colorectal cancer screening to people with Medicare?

Click on the following link:

<http://www.mrnc.org/crcreport2/>

The Carolinas Centers for Medical Excellence, Inc., the Quality Improvement Organization for North and South Carolina, calculated national, state, and county colorectal cancer screening rates using Medicare claims data from 1998-2004. The data indicate that over half (52%) of those eligible for screening had at least one test in the seven-year period.

Other highlights from the data:

- Although the largest group of people eligible for screening was composed of persons between the ages 65-74 (41% of those eligible), the rate of screening was highest among people ages 75-84 (59% screened);
- Test use was highest among Caucasians (53%), followed by Asians (46%), African Americans (45%), persons of Hispanic descent (45%), and Native Americans (35%);
- There was considerable disparity between the test rates for those eligible for only Medicare (54%) and persons eligible for both Medicare and Medicaid (43%);
- Persons eligible for Medicare due to a disability also had lower test rates (45%) than those eligible because of age (54%);
- Among the four covered tests, fecal occult blood test was the most commonly used test with a rate of 34%. Colonoscopy had the second highest use rate (31%), followed by sigmoidoscopy (14%) and barium enema (6%);
- Test use varied across states. In 2004, Rhode Island Medicare consumers had the highest test use (26% had one of the tests) and the lowest in Wyoming (13%)

CMS Needs Your Help

No part of the Medicare population has high rates of use of colorectal cancer screening tests. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope

that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For More Information

For information and resources to help you discuss colorectal cancer screening with your patients, visit the following American Cancer Society website:

http://www.cancer.org/colonmd?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=colonMD

Medicare-Covered Colorectal Cancer Screening Tests/Procedures:

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to Special Edition *MLN Matters* article:

SE0710 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf>.

Thank you for supporting CMS' effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

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March 30, 2007

Thanks for Your Help With National Colorectal Cancer Awareness Month!

Don't Forget to Follow-Up!

National Colorectal Cancer Awareness Month is almost over, but that doesn't mean the messages to your patients should stop until next year. Remind patients who have taken home a fecal occult blood test kit to use it. Follow up with patients on all screening results, even negative ones—everyone likes to hear good news. Remember, the appropriate follow-up for a positive fecal occult blood test result is a colonoscopy, not another fecal occult blood test.

Follow the Guidelines to Guide Next Steps When Polyps Are Found

A recent survey by the National Cancer Institute found that gastroenterologists and surgeons are performing surveillance colonoscopies at more frequent intervals than those recommended by evidence-based guidelines. For example, 24% of gastroenterologists and 54% of surgeons recommended a colonoscopy, either alone or with another procedure, at least every five years after the identification of a small, benign, hyperplastic polyp (Mysliwiec et al., 2004). Medical guidelines do not recommend any follow-up colonoscopy for hyperplastic polyps because their presence has not been shown to increase the risk of colorectal cancer. In contrast, adenomatous polyps ARE associated with cancer and people who have multiple polyps of this kind should be screened at shorter intervals.

Guidelines for surveillance after polypectomy were recently updated—here are references to two publications featuring these guidelines:

- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *Gastroenterology* 2006; 130:1872-1885.
- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *CA Cancer J Clin* 2006; May-Jun;56(3):143-59

For More Information

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to Special Edition *MLN Matters* article: SE0710 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf>.

The Centers for Medicare & Medicaid Services (CMS) website also has a “Prevention” website, which contains a section on colorectal cancer screening. From the CMS home page, www.cms.hhs.gov, select “Medicare” and scroll down to “Prevention” to find the colorectal cancer screening section.

Thank You for the Great Work!

Thank you for helping CMS spread the word regarding the importance of colorectal cancer screening. We are interested in knowing if the information we have provided over the last few weeks has been helpful, and if it has influenced your colorectal cancer screening practices. Please e-mail us at: Prevention@cms.hhs.gov

Remember – Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

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^[i] National Heart Lung and Blood Institute Diseases and Conditions Index;

http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html

^[ii] U.S. Preventive Services Task Force Screening for Abdominal Aortic Aneurysm: A Best Evidence Systematic Review

<http://www.ahrq.gov/clinic/uspstf05/aaascr/aaarev.htm>

I hope everyone enjoys a great weekend ~ Valerie

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