

Provider Partnership Program (PPP) E-mail Notification Archives

September 4, 2007

A Few Items to Start Your Week

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

Hello everyone! Just a few items to get your work week going, including information on:

- **Issuance of Hospice Wage Index for Fiscal Year 2008**
- **Reminder to Physicians Regarding the New CMS CAP Beneficiary Fact Sheet**
- **The Latest from CMS' Office of Research, Development and Information**

Issuance of Hospice Wage Index for Fiscal Year 2008

The Centers for Medicare & Medicaid Services (CMS) issued the "Hospice Wage Index for Fiscal Year 2008" final rule on Friday, August 31, 2007. To view the display version of the final rule (CMS-1539-F), see the Spotlight on <http://www.cms.hhs.gov/center/hospice.asp> on the CMS website.

Reminder to Physicians Regarding the New CMS CAP Beneficiary Fact Sheet

The following is a reminder to Participating CAP Physicians about the CMS CAP Beneficiary Fact Sheet entitled, "*New Billing for Certain Injectable and Infused Medicare Part B Drugs*."

Participating CAP Physicians are required to provide this fact sheet during a Medicare beneficiary's first visit to the physician's office subsequent to the start of a physician's participation in the CAP. When distributing the CAP Beneficiary Fact Sheet, physicians may include additional information, such as contact information for the Approved CAP Vendor. Participating CAP Physicians are only required to distribute the Beneficiary Fact Sheet once to each beneficiary, but may provide the beneficiary with additional copies as necessary.

The Beneficiary Fact Sheet is available in both English and Spanish. Use the following directions to order this document in English (Publication #11148). Up to 100 copies of

the fact sheet may be ordered at a time. If you have any problems ordering this document, send an email to mailpubs@cms.hhs.gov

1. Type in the URL address of the CMS Publications Mailing List:
<http://pubbordering.cms.hhs.gov/maillinglist>
2. Select the link “New user?” Register here.
3. Enter the password all lowercase: cms07
4. Create a username and enter it twice.
5. You will be prompted to change your password. The password can have numbers and/or letters. It must be at least five characters long.
6. When filling in your contact information choose the following category from the drop down menu: **Physicians**.
7. Proceed to fill in all forms required to register. If you do not add a shipping address after adding the contact information, you will not see the publications.
8. Please note that we do not ship publications to P.O. Boxes. Please refrain from including them in your address.

Both the English and Spanish versions are available in the “Downloads” section of the CAP web page on the CMS website at:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp.

The Latest from CMS’ Office of Research, Development and Information



News from ORDI

Summ

1. *Health Care Financing Review*

Since our last newsletter, ORDI published the Summer 2007 edition of the *Health Care Financing Review*, the agency’s journal of information, analysis and research on a broad range of health care financing and delivery issues. The Summer edition of the *Review* covers a number of general topics including the prescription drug plan, physician code creep, and dual eligibles. Click [here](#) to view the Summer edition. (There are also links on that page to previous issues.)

2. *CMS Statistics*

This useful publication provides significant summary information about health expenditures and CMS programs. The 2007 edition is available [here](#), along with links to previous editions.

3. *Wallet Card*

CMS offers to researchers and other health care professionals a broad range of quantitative information on our programs. The 2007 Wallet Card presents an overview of data from CMS programs, as well as financial data, in a compact form. The electronic version of the Wallet Card is available [here](#).

4. *Medicaid Analytic eXtract (MAX) Chartbook*

The *Medicaid Analytic eXtract (MAX) Chartbook* is a research tool and reference guide on Medicaid enrollees and their Medicaid experience in 2002. Developed for state Medicaid directors, policymakers, researchers, and others interested in the Medicaid program, the chartbook consists of illustrative graphs, descriptive text, and an extensive data appendix with summary national- and state-level information on enrollee demographic and eligibility characteristics, Medicaid service use, and Medicaid expenditures in 2002.

The *MAX Chartbook* (in PDF format) and its associated appendix tables (as zipped Excel files) can be downloaded from the CMS Medicaid Analytic eXtract web page [here](#). For additional information, please contact Dave Baugh at x67716.

5. *Current Demonstrations*

Medicare Care Management Performance Demonstration: In May and June, meetings were held in Massachusetts, Utah, California, and Arkansas to kick off the beginning of the Medicare Care Management Performance (MCMP) demonstration. The demonstration, which was authorized under section 649 of the Medicare Modernization Act, officially starts July 1st and is intended to improve the quality of care for chronically ill Medicare beneficiaries and encourage the adoption of electronic health records. Under this three year ‘pay for performance’ demonstration, primary care physicians will be eligible to earn financial incentives for performance on clinical quality measures relating to diabetes, congestive heart failure, coronary artery disease, and preventive health services. Practices that report the clinical quality data to CMS electronically from an electronic health record that is certified by the Certification Commission for Healthcare Information Technology (CCHIT) will be eligible to earn an additional incentive. Over the three year course of the demonstration, physicians will be eligible to earn up to \$38,500 and up to \$192,500 per practice. For additional information, please visit the demonstration website [here](#).

6. *New Research Reports Published*

- “Medicaid Populations with Chronic and Disabling Conditions: A Compilation of Data on Their Characteristics, Health Conditions, Service Use, and Medicaid Payments” by Carol V. Irvin and Christopher Johnson, Mathematica Policy Research Inc.

Description: This report was authored under CMS contract 500-00-0047/01. The report is based on data for calendar years 1999 and 2000 from the Medicaid Analytical Extract System (MAX) and from the disability files of the Social Security Administration (SSA). These data were used to identify Medicaid beneficiaries with special health care needs and to examine their wide range of chronic and disabling conditions. The report contains an extensive set of tables describing the demographic characteristics, chronic conditions, service utilization, and Medicaid payments for enrollees aged 0 through 64. It also presents tables, based on information from the SSA, on the disabling conditions that qualified beneficiaries for the SSI and SSDI programs. The report is available [here](#).

- “Evaluation of Impacts of Medicare Modernization Act Changes on Dual Eligible Beneficiaries in Demonstration and Other Managed Care and Fee-For-Service Settings. Final Report on Task 5: Examination of the Changing Context for Dual Demonstration Contractors” by Walter Leutz, Ph.D.; Deborah Gurewich, Ph.D.; Cindy Thomas, Ph.D.; Marian Ryan; Christine Bishop, Ph.D.

Description: This study was conducted under a contract from the Centers for Medicare & Medicaid Services (CMS) that had two aims: (1) describe best practices from 11 demonstration health plans operating in three states and offering comprehensive managed care to dual-eligible beneficiaries (eligible for both Medicare and Medicaid), and (2) assess the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the MMA) on these plans and their members. This report addresses the particular focus on MMA impacts in three areas: finances/the bidding process, marketing, and prescription drugs. The report is available [here](#).

7. CMS at Academy Health

At the 2007 Academy Health Annual Research Meeting, numerous CMS researchers held sessions on topics ranging from the Medicare Health Outcomes Survey to pay for performance. Each year, CMS seeks to share key findings in research and policy with the community of health service researchers and policy analysts attending this meeting. A list of CMS presentations, with links to presentation slides, may be viewed [here](#). Other presentations from the AcademyHealth Annual Research Meeting 2007 may be viewed at: <http://www.academyhealth.org/arm/agenda/sunday.htm>

Hope it's a good week for you ~ Valerie

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

Important NPI Information for Medicare Providers

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

Important Information for Medicare Providers

Incorrect Implementation Schedule Published

It has come to CMS' attention that a trade publication recently published a schedule of implementation dates, by contractor, for claim rejections based on the inability to locate an NPI/legacy identifier pair on the Medicare NPI Crosswalk. The dates listed in the publication are incorrect. Providers will be advised by their Medicare contractor as to the particular timeframe for their transition. Any other published schedules are unofficial and may have inaccurate dates. Medicare providers are urged to only rely on information from their Medicare contractors.

Providers may find a recent MLN Matters article helpful in determining how to use the NPI on Part A and Part B claims. You can view the article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website.

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

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

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September 5, 2007

Updated Information Regarding the Medicare Part B Drug Competitive Acquisition Program (CAP)

If you elected to participate in the Medicare Part B Drug Competitive Acquisition Program (CAP) during the *May 1 to June 15, 2007 election period*, you should have received a welcome telephone call from the Approved CAP Vendor, Bioscrip, Inc.

If you have NOT yet received a welcome call from the Approved CAP Vendor and expected to begin participating in the CAP effective August 1, 2007, please contact your local carrier (the carrier that processes Part B drug claims) to inquire about the processing status of your physician election materials. Your local carrier's contact information may be found at the following CMS website: http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

You may also contact the Approved CAP Vendor at 1-888-899-7447 to determine whether they have received your information. If your local carrier and the Approved CAP Vendor are unable to resolve your questions, you may also request assistance from the Designated CAP Carrier, Noridian Administrative Services, at 1-888-671-0536.

Please note that no action is required if you did not submit a CAP physician election form during the May 1 to June 15, 2007 CAP physician election period.

The next CAP physician election period will occur from *October 1, 2007 until November 15, 2007*.

#

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

Upcoming workshops will be held on the following dates:

- 9/12/07 at 2:00 pm Central Time
- 10/18/07 at 12:00 pm Central Time

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September 12, 2007

October 1, 2007 Implementation of MS-DRGs

October 1, 2007 Implementation of MS-DRGs

Medicare Severity DRGs (MS-DRGs) will be implemented for discharges occurring on or after October 1, 2007 as was announced in the inpatient prospective payment system (IPPS) final rule (CMS-1533-FC). As stated in this rule, we believe MS-DRGs represent a substantial improvement over the current CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption. As developed, the MS-DRGs increase the number of DRGs by 207, while maintaining a reasonable patient volume in each DRG.

Complete information on MS-DRGs is currently available as follows:

Documents on the Acute Inpatient Prospective Payment System Website -
<http://www.cms.hhs.gov/AcuteInpatientPPS>

[Final rule \(CMS-1533-FC\) – under IPPS Regulations and Notices](#)

Downloadable files, including those listed below under Acute Inpatient – Files for Download

- [Complications and Comorbidities \(CC\) – Table 6J – CC List](#)
- [Major Complications and Comorbidities \(MCC\) – Table 6I – MCC List](#)
- [CC Exclusions – Total CC Exclusion List, Table 6G - Additions to the CC Exclusions List, and Table 6H - Deletions from the CC Exclusions List](#)
- [Crosswalk from CMS DRGs to MS-DRGs](#)

Version 25.0 of the Grouper Logic

Version 25.0 of the Grouper manual is available from:

3M/HIS

100 Barnes Road

Wallingford, CT 06492

(203) 949-0303

Hard copy Grouper manual	\$250.00
CD version Grouper manual	\$200.00
Combination hard copy and CD versions	\$400.00

Version 25.0 of Grouper Software from NTIS

<http://www.ntis.gov/products/families/cms/grouper.asp?loc=4-1-0>

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September 14, 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!

Happy Friday everyone! A few items this week, including information on:

- The National Provider Identifier (NPI)
- National Conference Calls on the 2007 Physician Quality Reporting Initiative (PQRI)
- A Physician-Focused "Ask the Contractor" Teleconference
- The Latest Article from CMS' 'Dr. Bill'
- New from the Medicare Learning Network



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

The NPI Registry and the downloadable file are now available. To view the Registry, visit <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do> on the web. The downloadable file is available at http://nppesdata.cms.hhs.gov/cms_NPI_files.html on the web.

Additionally, the final module in the NPI Training Package is now available. Module 4, Data Dissemination, is now available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Module4_Data_Dissemination.pdf on the CMS website. This module describes the policy by which CMS will make certain NPPES data available, as well as the data CMS is disclosing.

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

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

National Provider Conference Calls on the 2007 Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the seventh in a series of national provider conference calls on the 2007 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 1:30 p.m. – 3:30 p.m., EDT, on Wednesday, September 26, 2007.

Physicians and other eligible professionals started submitting claims with PQRI quality data codes on them as of July 1, 2007. This toll-free question and answer teleconference will provide eligible professionals the opportunity to ask questions of CMS subject matter experts.

Educational resources on the 2007 Physician Quality Reporting Initiative are posted to the PQRI web page located at, <http://www.cms.hhs.gov/PQRI>, on the CMS website, in the Educational Resources section. Feel free to download the resources prior to the call so that you may ask questions of the presenter, Dr. Susan Nedza.

Conference call details:

Date: September 26, 2007
Conference Title: 2007 Physician Quality Reporting Initiative-National Provider Call
Time: 1:30-3:30 p.m. EDT

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

Registration will close at 1:30 p.m. EDT on September 25, 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/event/14fb1aa76c244fe69df774507877a71f>
2. Fill in all required data.
3. Verify your time zone is displayed correctly in the drop down box.
4. Click "Register".
5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who will be unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 5:30 p.m. EDT 09/26/2007 until 10/03/2007, 11:59 p.m. EDT. The call in data for the replay is (800) 642-1687 and the passcode is 15652356.

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

Physician-Focused Ask the Contractor Teleconference (ACT)

The National Contractor for the Section 1011 program, TrailBlazer Health Enterprises, LLC, is hosting a Physician-Focused Ask the Contractor Teleconference (ACT) on **Wednesday, September 19, 2007, from 1-3 p.m. (C.T.)**.

Register for the event on the calendar of events page of the Section 1011 website:

<http://www.trailblazerhealth.com/section1011>

This physician-specific, question-driven ACT provides a program overview and updates and allows providers the opportunity to participate in a live question and answer segment. Questions for the teleconference should be submitted in advance through the close of business, Friday September 14, 2007. E-mail questions to section.1011@trailblazerhealth.com with the subject titled "ACT-Physician Question". The ACT will also conclude with live questions and answers.

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. Contact Section 1011 Customer Service toll free at (866) 860-1011 or send an e-mail to section.1011@trailblazerhealth.com with any questions you may have.

The Latest Article from CMS' 'Dr. Bill'

William D. Rogers, M.D., FACEP, Medical Officer in the Office of the Administrator Director at CMS, shares his most recent thoughts regarding Recovery Audit Contractors. Please read more in the attached article.



New from the Medicare Learning Network!

A new preventive services brochure entitled ***Diabetes-Related Services***, ICN# 006840, is now available from the Centers for Medicare & Medicaid Services' (CMS), Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. The new brochure is available as a downloadable pdf file on the Medicare Learning Network's (MLN) Publications web page at <http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf> on the CMS website.

In addition, the following preventive services brochures have recently been updated:

- ***Adult Immunizations***, ICN# 006435
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration.
http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf
- ***Bone Mass Measurements***, ICN# 006437
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of bone mass measurement services.
http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf

- **Cancer Screenings**, ICN# 006434
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the following screening services: mammography, colorectal, prostate, Pap test, and pelvic exam.
http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf
- **Expanded Benefits**, ICN# 006433
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the Welcome to "Medicare Physical" Exam or the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.
http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf
- **Glaucoma Screening**, ICN# 006436
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services.
<http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf>
- **Smoking and Tobacco-Use Cessation Counseling Services**, ICN# 006767
This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of smoking cessation services.
<http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf>

These seven national provider education brochures are currently available for download on the MLN Products web page as pdf files. Print copies of these brochures will be available in approximately 4 to 6 weeks.



Recovery Audit
Contractors Article At

I hope you have a great weekend!

With best regards ~ Valerie

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

September 17, 2007

NPPES and NPI Registry will be Unavailable on September 18th

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

On Tuesday, September 18, 2007, CMS will be making changes in NPPES. While these changes are made, NPPES and the NPI Registry will not be available. We expect NPPES and the NPI Registry to be back in operation before the end of the day. We apologize for any inconvenience.

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

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September 18, 2007

Medicare Part B Drug Competitive Acquisition Program (CAP): 2008 Physician Election

Medicare Part B Drug Competitive Acquisition Program (CAP): 2008 Physician Election

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on October 1, 2007 and concludes on November 15, 2007. The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. The 2008 CAP program will run from January 1 to December 31, 2008.

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

Additional information about the CAP is available at the following website:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

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

http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

Please note that completed and signed physician election forms should be returned by mail to your local carrier. Forms must be postmarked on or before November 15, 2007. DO NOT return forms to CMS offices.

More detailed information will be available in an upcoming Medicare Learning Network (MLN) Matters Article.

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

September 21, 2007

Important Message about the NPI Registry!

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

Important Message about the NPI Registry!

Many of you have noted the recent instability of NPES and the NPI Registry. CMS has begun implementing changes that should eliminate the instability. We expect that these changes will be completed next week. NPES will remain in operation while these changes are being made, but the NPI Registry will remain down until all changes have been implemented. We expect the NPI Registry to be back in operation sometime next week. We apologize for this inconvenience.

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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! Just three items this afternoon, including information on:

- Medicare Part B Drug and Biological Average Sales Price Payment Amounts for October 1, 2007
- National Adult Immunization Awareness Week
- New from the Medicare Learning Network



Medicare Part B Drug and Biological Average Sales Price Payment Amounts for October 1, 2007

The Centers for Medicare & Medicaid Services (CMS) has made available the Medicare Part B Drug and Biological Average Sales Price (ASP) Payment Amounts for October 1, 2007 to

December 31, 2007 on the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp . The files are located in the "Downloads" section of this web page.

National Adult Immunization Awareness Week

September 23 – 29, 2007 is National Adult Immunization Awareness Week. This annual health observance is a great opportunity to promote the importance of adult immunizations. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for flu, pneumococcal, and hepatitis B vaccines and their administration. All adults 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for hepatitis B should get hepatitis B shots. CMS needs your help to ensure that people with Medicare take full advantage of these vital preventive benefits. You can help by talking with your Medicare patients about their risk for these vaccine-preventable diseases covered by Medicare and the steps they can take to help reduce their risk of contracting these diseases, including getting vaccinated.

For more information about Medicare's coverage of adult immunizations and a list of related educational resources, please visit CMS' Medicare Learning Network Preventive Services Educational Products web page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS website.

For information about National Adult Immunization Awareness Week, go to <http://www.cdc.gov/vaccines/events/naiaw/default.htm#kit>



New from the Medicare Learning Network

- **New Medicare Preventive Services Quick Reference Information Chart Now Available**

The Medicare Learning Network has just released a new preventive services quick reference chart entitled ***The ABCs of Providing the Initial Preventive Physical Examination***, ICN# 006904. This two-sided laminated chart can be used by Medicare fee-for-service physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Currently available in downloadable PDF format, the chart can be viewed at, http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf, on the

CMS Medicare Learning Network Publications web page. Laminated copies of the IPPE chart will be available in approximately 4 to 6 weeks.

I hope everyone enjoys a very nice weekend!

With best regards ~ Valerie

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Visit the [Medicare Learning Network](http://www.cms.hhs.gov/medlearn) ~ it's free!

September 24, 2007

NPI: NPPES & NPI Registry Update; Important Information for Medicare Providers

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

Many of you have noted the recent instability of NPPES and the NPI Registry. CMS has begun implementing changes that should eliminate the instability. We expect that these changes will be completed as soon as possible. NPPES will remain in operation while these changes are being made but the NPI Registry will remain down until all changes have been implemented. We expect the NPI Registry to be back in operation as soon as possible. We apologize for this inconvenience.

The downloadable file is available at http://nppesdata.cms.hhs.gov/cms_NPI_files.html on the web.

Important Information for Medicare Providers

For Physicians and Non-Physician Practitioners who Bill Medicare

Your Medicare carrier has contacted, or will be contacting you, about the date Medicare will begin rejecting your claims if the NPI and legacy number pairs used on your Medicare claims are not compatible. If you bill using only the NPI, please skip to the last paragraph.

Some incorporated physicians and non-physician practitioners have obtained NPIs as follows: an individual (Entity Type 1) NPI for the physician or non-physician practitioner and an organization (Entity Type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare Provider Identification Number (PIN) as an individual, and you want to use your NPI

and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

NPI-Only Billers: Make sure the NPI you are using is compatible with your Medicare enrollment. For example, if you enrolled in Medicare as an individual, then you should be using an individual (Entity Type 1) NPI.

Enumeration Tip for DME Suppliers

Medicare has also reported instances of incorrect billing by DME suppliers to DME MACs. DME suppliers must ensure that if they enumerate as individuals in the National Supplier Clearinghouse (NSC), they must obtain NPIs for themselves as individuals (Entity type 1) in NPPES. If they enumerate as organization in the NSC, they must obtain NPIs for the organizations (Entity type 2) in NPPES.

Pay Attention: Informational Edits Today = Future Claim Rejections!

We strongly urge Medicare providers to pay attention to the informational edits they may be receiving on the remittance advice (either electronic or paper). These edits are generated to help providers identify problems that will cause claims to reject in the future. A recent MLN Matters article lists these informational edits and their meanings. Visit <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website to view the article.

Reminder ---Medicare Carriers and DME MACs Will Begin Transitioning their Systems to Start Rejecting Claims when the NPI and Legacy Provider Identifier Pair 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 NPI Crosswalk.

If your remittance advice contains 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 informational edits, you should ensure that your Medicare enrollment information is up to date. If it is not, you may need to submit a completed CMS-855 (Medicare provider enrollment form). When completing the CMS-855, please list all of the NPIs that will be used in place of legacy identifiers. When applying for an NPI, please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 Other Provider Identifiers, but is being expanded to accept more in the future.) If the information is different between Medicare and NPPES, there is a very good chance your claims will reject. NPPES data may be verified at <https://nppes.cms.hhs.gov> on the web.

Clarification Regarding Provider Response Times for Contractor Inquiries

As stated in CR 5649, Transmittal number 1262 dated June 8, 2007, 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. In last month's NPI message, we noted the number of days for a provider to respond to this type of contractor inquiry. To clarify, if the provider does not respond within the timeframe issued during the phone call with, or on the letter they receive from their contractor, the contractor will return the claim as unprocessable. 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.

Upcoming WEDI NPI Audiocast

The Workgroup for Electronic Data Interchange will host an NPI audiocast on October 17th. Visit <http://www.wedi.org/npioi/index.shtml> on the WEDI website to learn more. Please note that there is a cost 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 through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

Nicole M. Cooney for Valerie Haugen

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September 25, 2007

Medicare Part B Drug Competitive Acquisition Program (CAP) "Ask the Contractor" Teleconference

Medicare Part B Drug Competitive Acquisition Program (CAP): Ask the Contractor Teleconference on October 3, 2007 at 2 P.M. CST

The designated carrier for CAP, Noridian Administrative Services (NAS), will hold an Ask the Contractor Teleconference on October 3, 2007 at 2 p.m. CST. Prospective CAP physicians will have an opportunity to learn more about CAP and how to elect into the program during the upcoming 2008 physician election period. Additionally, NAS staff will be available to answer questions. To participate in the teleconference, please dial (877) 260-8899 on October 3, 2007. No prior registration is required.

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on October 1, 2007 and will conclude on November 15, 2007. For more information about CAP, please visit the CMS CAP website at: <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>

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COBA Medigap Claim-Based Identifiers

The Centers for Medicare & Medicaid Services (CMS) has made a decision to **delay the use** of the new Coordination of Benefits Agreement (COBA) Medigap claim-based identifiers on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) **until October 1, 2007**. This represents a change from previous CMS direction issued in accordance with Transmittal 283, Change Request (CR) 5662, and the accompanying *MLN Matters* article.

Because of the CMS delay, physicians and other suppliers shall inform their billing vendors not to include any newly assigned 5-byte COBA Medigap claim-based identifiers, as referenced at

<http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf>, on incoming Medicare claims before October 1, 2007. If participating providers or suppliers include the newly assigned COBA Medigap claim-based ID on incoming claims before October 1, 2007, Medicare will not cross the claims over to the Medigap insurer.

Providers that use PC-Ace or other free billing Medicare software need to ensure this product is updated to reflect the newly assigned 5-byte COBA Medigap claim-based IDs

but must ensure that the new identifiers will not be applied on incoming Medicare claims before October 1, 2007.

Effective with October 1, 2007, and as specified in Transmittal 283, CR 5662, physicians and other suppliers that bill using paper forms, i.e., those granted an exception for billing electronically under the Administrative Simplification Compliance Act (ASCA), shall include the newly assigned 5-byte identifier (number will fall in the range 55000 through 59999) within item 9-D of incoming paper CMS-1500 claim forms. These providers should complete items 9A through 9D, in accordance with previous procedures, to ensure they will successfully trigger a Medigap claim-based crossover. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) in field NM109 of the NM1 segment within the 2330B loop. Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier within field 301-C1 of the T04 segment of their incoming NCPDP claims.

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DMEPOS Competitive Bidding Program Reminder

This a reminder that all bids for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program are due by **9:00 p.m. prevailing Eastern Time TODAY--September 25, 2007**. Please remember that suppliers must be accredited or be pending accreditation to submit a bid, and will need to actually **be accredited by October 31, 2007** to be considered for a contract award. For more information on the program as well as bidding and accreditation information, please visit <http://www.dmecompetitivebid.com> or <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS>.

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September 27, 2007

**Ambulance-Focused Ask the Contractor Teleconference (ACT)
Regarding Section 1011**

The National Contractor for Section 1011, TrailBlazer Health Enterprises, LLC, is hosting an Ambulance-Focused Ask the Contractor Teleconference (ACT) on **Tuesday, October 2, 2007, from 1-3 p.m. (C.T.)**.

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

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

Questions for the teleconference should be submitted in advance through the close of business, Friday September 28, 2007. E-mail questions to section.1011@trailblazerhealth.com with the subject titled "ACT-Ambulance Question." The ACT will also conclude with live questions and answers.

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. Contact Section 1011 Customer Service toll free at (866) 860-1011 or send an e-mail to section.1011@trailblazerhealth.com with any questions you may have.

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September 28, 2007

Physician Payment Information for Value-Driven Health Care

CMS Updates Physician Payment Information for Value-Driven Health Care (9-28-07)

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 and August 29, 2007, Medicare updated last year's inpatient hospital and ASC data, respectively. On Thursday, September 27, 2007, we posted an update to last year's physician services data, including anesthesia services. In addition, we added a table reflecting physician payment data for many Medicare covered preventive services. 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:

www.cms.hhs.gov/HealthCareConInit/

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Update Regarding DMEPOS Competitive Bidding

New CBIC Service Center Hours of Operation

The CMS DMEPOS Competitive Bidding Implementation Contractor (CBIC) customer service center will provide **new hours of operation beginning Monday, October 1, 2007**. The CBIC customer service center associates will be available to assist you from **9 am EST to 5:30 pm EST, Monday through Friday**. In addition, you may e-mail your questions, comments or issues to cbic.admin@palmettogba.com at any time.

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

Your Friday Reading Materials

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

Happy Friday everyone! A few items this week, including information on:

- The National Provider Identifier (NPI)
- National Conference Calls on the 2007 Physician Quality Reporting Initiative (PQRI)
- A Physician-Focused "Ask the Contractor" Teleconference
- The Latest Article from CMS' 'Dr. Bill'

- New from the Medicare Learning Network



**PROGRAM ADVISORY and OVERSIGHT COMMITTEE (PAOC) UPDATE
MEETING ON THE MEDICARE IMPLEMENTATION OF THE
COMPETITIVE ACQUISITION FOR CERTAIN DURABLE MEDICAL
EQUIPMENT, PROSTHETICS, ORTHOTICS, and SUPPLIES PROGRAM**

**October 11, 2007
8:00 a.m. - 5:00 p.m. (Eastern Standard Time)**

The Centers for Medicare & Medicaid Services (CMS) will be hosting a meeting with the PAOC members on October 11, 2007 to discuss the operational issues of the Medicare Competitive Bidding Program. The agenda is focused on CMS' progress of implementing the competitive bidding program since CMS issued the final regulation in April of this year. Representatives from a number of the CMS components will lead the discussions on key education and operational issues. CMS hopes that the feedback we receive from the PAOC committee members and the public will assist us in moving forward with a smoother transition on the next round of competitive bidding.

We look forward to your participation.

For registration information, go to:

<http://www.blsmeetings.net/H1102>

For more information about the PAOC, go to the following URLs:

<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/PAOCMI/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1203655&intNumPerPage=10>

<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/PAOCMI/list.asp>

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/paoc_member_list.pdf

For more information about the Competitive Bidding Program, go to:

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp

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

Hello everyone! Several items this afternoon (in addition to the ones I have already sent you this week), including information on:

- Certification for Current Medicare-Approved Organ Transplant Centers
- National Breast Cancer Awareness Month

- New from the Medicare Learning Network
- User Fees for Conducting Revisit Surveys
- Medicare Provider Feedback Town Hall Meeting



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. 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.

October is National Breast Cancer Awareness Month (NBCAM) ~ In conjunction with NBCAM, the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the United States. *National Breast Cancer Awareness Month* educates women about the importance of early detection. The good news is, more and more women are getting mammograms to detect breast cancer in its earliest stages. As a result, breast cancer deaths are on the decline. This is exciting progress. Yet, while mammography screening remains the best available method to detect breast cancer, there are still many eligible women with Medicare who do not take advantage of early detection at all and others who do not get screening mammograms and clinical breast exams at regular intervals.

Medicare Coverage

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older and one baseline mammogram for female beneficiaries between the ages of 35 and 39. Medicare also provides coverage of clinical breast exams, every 12 or 24 months depending on risk level for the disease. (clinical breast exams are covered by Medicare as part of the pelvic screening exam)

How Can You Help?

“Pass the Word.” Early detection of breast cancer results in earlier potentially less invasive treatment and an improved chance of survival. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible.

- Help your patients understand their risk for breast cancer and the benefits of regular screening mammograms and clinical breast exams.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.
- Make sure that all eligible female patients are aware that Medicare covers mammography screenings every year and regular clinical breast exams.

Please encourage women with Medicare to take full advantage of these vitally important benefits.

For More Information

- For more information about Medicare’s coverage of screening mammography, and clinical breast exams, including coverage, coding, billing, and reimbursement, please visit the CMS Medicare Learning Network web page: <http://www.cms.hhs.gov/Mammography/>
 - The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>

- For more information about NBCAM, please visit www.nbcam.org

Thank you for joining with CMS in promoting increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare.

FLU SHOT REMINDER!

Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. Encourage them to get their flu shot. It's their best defense against combating the flu this season. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*) And don't forget, health care professionals need to protect themselves also. **Get Your Flu Shot. – Not the Flu.** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website.



New from the Medicare Learning Network

The revised ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*** (Ninth Edition), which 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, is now available in print and CD-Rom formats from the ***Medicare Learning Network***. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

User Fees for Conducting Revisit Surveys

The Centers for Medicare & Medicaid Services works with State survey agencies to conduct survey and certification visits to assure compliance with quality standards and to be assured that Medicare or Medicaid certified providers are meeting statutory and regulatory requirements, conditions of participation or conditions for coverage.

The 2007 Continuing Appropriations Resolution (Pub. L. No. 110-5, H.J.Res.20, §20615(b)(2007)) directed the Department of Health and Human Services to charge user fees necessary for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys. The user fees only apply to the following Medicare-certified providers and suppliers: skilled nursing facilities/dually-certified nursing facilities, hospitals (including psychiatric hospitals and critical access hospitals), home health agencies, hospices, ambulatory surgical centers, rural health clinics and end stage renal disease facilities.

These user fees do not apply, at this time, to comprehensive outpatient rehabilitation facilities (CORFs), providers of outpatient physical therapy centers (OPTs), transplant centers or programs, religious nonmedical healthcare institutions (RNHCIs), Federally qualified health centers (FQHCs), community mental health centers (CMHCs), independent laboratories, physical therapists in independent practice, chiropractors, and portable x-ray centers.

Revisit surveys are performed when there are findings of deficiencies in patient care or processes that were identified in an earlier survey and are conducted to assure that the deficiencies have been corrected. The primary purpose for the user fees is to provide for the continuation of CMS Survey and Certification quality assurance efforts to improve patient care and safety. We also believe that these user fees will assure greater commitment to compliance for correcting identified quality of care problems.

The fees were effective on September 19, 2007 until the end of the 2007 federal fiscal year, which concludes on September 30, 2007. CMS will use the current fee schedule until such time as a new fee schedule notice is proposed and published in final form.

Final Fee Schedule for Revisit Surveys (Onsite and Offsite)

Facility	Fee assessed per offsite revisit survey	Fee assessed per onsite revisit survey
Skilled Nursing Facility and Nursing Facility	\$168	\$2,072
Hospitals	\$168	\$2,554
Home Health Agency	\$168	\$1,613
Hospice	\$168	\$1,736
Ambulatory Surgical Centers	\$168	\$1,669
Rural Health Clinic	\$168	\$ 851
End Stage Renal Disease Facility	\$168	\$1,490

Fees are based on the cost that CMS incurs as a result of the time and effort for State surveyors to conduct follow up as a result of deficiencies found. Providers and suppliers have the right to reconsideration if they feel an error of fact has been made in the application of the user fee, such as clerical errors, billing for a fee already paid or assessment of a fee when there was no revisit scheduled. A request for reconsideration must be received by CMS within 14 calendar days from the date identified on the revisit user fee assessment notice.

Providers who are assessed a revisit user fee will receive a notice in the mail which will include the amount of the assessed fee. Payment must be received within 30 days or CMS could terminate the facility's enrollment and participation in the Medicare program. If you have additional questions, contact Carla.McGregor@cms.hhs.gov.

MEDICARE PROVIDER FEEDBACK TOWN HALL MEETING
OCTOBER 16, 2007
2:00 - 4:00 PM ET

The Centers for Medicare & Medicaid Services (CMS) requests your participation in a Town Hall meeting on October 16, 2007, from 2:00 PM to 4:00 PM (Eastern Time). The meeting will be held in the auditorium at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 and by teleconference.

The purpose of the meeting is to capture individual provider feedback on relevant Fee-for-Service (FFS) Medicare policy and operational issues. By doing so we further advance CMS' efforts to strengthen the Medicare program and enhance its relationship with providers and suppliers. This Town Hall meeting also provides a venue to allow CMS staff to continue a process to engage individual providers and suppliers through the following year. This meeting is open to all Medicare FFS providers and suppliers that participate in the Medicare program, including, but not limited to, physicians, hospitals, home health agencies, and other third-party billers.

The agenda topics include: Value Based Purchasing (VBP), Medicare Provider Satisfaction Survey (MCPSS), Medicare Contracting Reform (MCR), FFS Implementation of the National Provider Identifier (NPI) and are available in the September 28, 2007 Federal Register Notice. Meeting agenda and discussion materials will be available to download at www.cms.hhs.gov/center/provider.asp by October 12, 2007. CMS will conduct a dialogue session at the meeting that offers meeting participants an opportunity to provide feedback on agenda topics.

Please note: Due to time constraints not all participants will have an opportunity to speak, but written submissions will be accepted at MFG@cms.hhs.gov. CMS will give consideration to feedback received but written responses will not be provided.

Meeting Registration Details

All participants must pre-register for the meeting through on-line registration located at <http://registration.intercall.com/go/cms2>. Registration will open on September 28, 2007 and will close on October 12, 2007. Registered participants may be contacted for follow-up meetings to solicit additional individual opinions and clarify any issues that may arise during the October 16 Town Hall meeting.

You will receive a confirmation page to indicate the completion of your registration. Please print this page as your registration receipt. We encourage you to complete your registration as soon as possible. **Registration after 5:00 p.m. on October 12, 2007, will not be accepted.**

Meeting Participation Details

All persons attending the meeting in person will be required to show a photographic identification (a valid driver's license or passport). Further details can be found in the September 28, 2007 Federal Register Notice.

Additional Questions/Information

For questions or additional information about the Medicare Provider Feedback Town Hall Meeting, please send an email to MFG@cms.hhs.gov

I hope you enjoy a wonderful weekend ~ Valerie

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Take 2: Your Friday Reading Materials

Okay, let's try this again, shall we? Please disregard the first message of "Your Friday Reading Materials" as it contained segments of last week's message that should not have been included. My apologies!

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- Notice of PAOC Update Meeting
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**PROGRAM ADVISORY and OVERSIGHT COMMITTEE (PAOC) UPDATE
MEETING ON THE MEDICARE IMPLEMENTATION OF THE
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EQUIPMENT, PROSTHETICS, ORTHOTICS, and SUPPLIES PROGRAM**

October 11, 2007

8:00 a.m. - 5:00 p.m. (Eastern Standard Time)

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We look forward to your participation.

For registration information, go to:

<http://www.blsm meetings.net/H1102>

For more information about the PAOC, go to the following URLs:

<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/PAOCMI/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1203655&intNumPerPage=10>

<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/PAOCMI/list.asp>

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/paoc_member_list.pdf

For more information about the Competitive Bidding Program, go to:

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp

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Ask the Contractor Teleconference on October 3, 2007 at 2 P.M. CST**

The designated carrier for CAP, Noridian Administrative Services (NAS), will hold an Ask the Contractor Teleconference on October 3, 2007 at 2 p.m. CST. Prospective CAP physicians will have an opportunity to learn more about CAP and how to elect into the program during the upcoming 2008 physician election period. Additionally, NAS staff will be available to answer questions. To participate in the teleconference, please dial (877) 260-8899 on October 3, 2007. No prior registration is required.

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on October 1, 2007 and will conclude on November 15, 2007. For more information about CAP, please visit the CMS CAP website at: <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>

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. 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.

October is National Breast Cancer Awareness Month (NBCAM) ~ In conjunction with NBCAM, the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the United States. *National Breast Cancer Awareness Month* educates women about the importance of early detection. The good news is, more and more women are getting mammograms to detect breast cancer in its earliest stages. As a result, breast cancer deaths are on the decline. This is exciting progress. Yet, while mammography screening remains the best available method to detect breast cancer, there are still many eligible women with Medicare who do not take advantage of early detection at all and others who do not get screening mammograms and clinical breast exams at regular intervals.

Medicare Coverage

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older and one baseline mammogram for female beneficiaries between the ages of 35 and 39. Medicare also provides coverage of clinical breast exams, every 12 or 24 months depending on risk level for the disease. (clinical breast exams are covered by Medicare as part of the pelvic screening exam)

How Can You Help?

“Pass the Word.” Early detection of breast cancer results in earlier potentially less invasive treatment and an improved chance of survival. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible.

- Help your patients understand their risk for breast cancer and the benefits of regular screening mammograms and clinical breast exams.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.
- Make sure that all eligible female patients are aware that Medicare covers mammography screenings every year and regular clinical breast exams.

Please encourage women with Medicare to take full advantage of these vitally important benefits.

For More Information

- For more information about Medicare’s coverage of screening mammography, and clinical breast exams, including coverage, coding, billing, and reimbursement, please visit the CMS Medicare Learning Network web page: <http://www.cms.hhs.gov/Mammography/>
 - The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>
- For more information about NBCAM, please visit www.nbcam.org

Thank you for joining with CMS in promoting increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare.

FLU SHOT REMINDER!

Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. Encourage them to get their flu shot. It's their best defense against combating the flu this season. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*) And don't forget, health care professionals need to protect themselves also. **Get Your Flu Shot. – Not the Flu.** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website.



New from the Medicare Learning Network

The revised ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*** (Ninth Edition), which 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, is now available in print and CD-Rom formats from the **Medicare Learning Network**. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

User Fees for Conducting Revisit Surveys

The Centers for Medicare & Medicaid Services works with State survey agencies to conduct survey and certification visits to assure compliance with quality standards and to be assured that Medicare or Medicaid certified providers are meeting statutory and regulatory requirements, conditions of participation or conditions for coverage.

The 2007 Continuing Appropriations Resolution (Pub. L. No. 110-5, H.J.Res.20, §20615(b)(2007)) directed the Department of Health and Human Services to charge user fees necessary for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys. The user fees only apply to the following Medicare-certified providers and suppliers: skilled nursing facilities/dually-certified nursing facilities, hospitals (including psychiatric hospitals and critical access hospitals), home health agencies, hospices, ambulatory surgical centers, rural health clinics and end stage renal disease facilities. These user fees do not apply, at this time, to comprehensive outpatient rehabilitation facilities (CORFs), providers of outpatient physical therapy centers (OPTs), transplant centers or programs, religious nonmedical healthcare institutions (RNHCIs), Federally qualified health centers (FQHCs), community mental health centers (CMHCs), independent laboratories, physical therapists in independent practice, chiropractors, and portable x-ray centers.

Revisit surveys are performed when there are findings of deficiencies in patient care or processes that were identified in an earlier survey and are conducted to assure that the deficiencies have been corrected. The primary purpose for the user fees is to provide for the continuation of CMS Survey and Certification quality assurance efforts to improve patient care and safety. We also believe that these user fees will assure greater commitment to compliance for correcting identified quality of care problems.

The fees were effective on September 19, 2007 until the end of the 2007 federal fiscal year, which concludes on September 30, 2007. CMS will use the current fee schedule until such time as a new fee schedule notice is proposed and published in final form.

Final Fee Schedule for Revisit Surveys (Onsite and Offsite)

Facility	Fee assessed per offsite revisit survey	Fee assessed per onsite revisit survey
Skilled Nursing Facility and Nursing Facility	\$168	\$2,072
Hospitals	\$168	\$2,554
Home Health Agency	\$168	\$1,613
Hospice	\$168	\$1,736
Ambulatory Surgical Centers	\$168	\$1,669
Rural Health Clinic	\$168	\$ 851
End Stage Renal Disease Facility	\$168	\$1,490

Fees are based on the cost that CMS incurs as a result of the time and effort for State surveyors to conduct follow up as a result of deficiencies found. Providers and suppliers have the right to reconsideration if they feel an error of fact has been made in the application of the user fee, such as clerical errors, billing for a fee already paid or assessment of a fee when there was no revisit scheduled. A request for reconsideration must be received by CMS within 14 calendar days from the date identified on the revisit user fee assessment notice.

Providers who are assessed a revisit user fee will receive a notice in the mail which will include the amount of the assessed fee. Payment must be received within 30 days or CMS could terminate the facility's enrollment and participation in the Medicare program. If you have additional questions, contact Carla.McGregor@cms.hhs.gov.

**MEDICARE PROVIDER FEEDBACK TOWN HALL MEETING
OCTOBER 16, 2007
2:00 - 4:00 PM ET**

The Centers for Medicare & Medicaid Services (CMS) requests your participation in a Town Hall meeting on October 16, 2007, from 2:00 PM to 4:00 PM (Eastern Time). The meeting will be held in the auditorium at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 and by teleconference.

The purpose of the meeting is to capture individual provider feedback on relevant Fee-for-Service (FFS) Medicare policy and operational issues. By doing so we further advance CMS' efforts to strengthen the Medicare program and enhance its relationship with providers and suppliers. This Town Hall meeting also provides a venue to allow CMS staff to continue a process to engage individual providers and suppliers through the following year. This meeting is open to all Medicare FFS providers and suppliers that participate in the Medicare program, including, but not limited to, physicians, hospitals, home health agencies, and other third-party billers.

The agenda topics include: Value Based Purchasing (VBP), Medicare Provider Satisfaction Survey (MCPSS), Medicare Contracting Reform (MCR), FFS Implementation of the National Provider Identifier (NPI) and are available in the September 28, 2007 Federal Register Notice. Meeting agenda and discussion materials will be available to download at www.cms.hhs.gov/center/provider.asp by October 12, 2007. CMS will conduct a dialogue session at the meeting that offers meeting participants an opportunity to provide feedback on agenda topics.

Please note: Due to time constraints not all participants will have an opportunity to speak, but written submissions will be accepted at MFG@cms.hhs.gov. CMS will give consideration to feedback received but written responses will not be provided.

Meeting Registration Details

All participants must pre-register for the meeting through on-line registration located at <http://registration.intercall.com/go/cms2>. Registration will open on September 28, 2007 and will close on October 12, 2007. Registered participants may be contacted for follow-up meetings to solicit additional individual opinions and clarify any issues that may arise during the October 16 Town Hall meeting.

You will receive a confirmation page to indicate the completion of your registration. Please print this page as your registration receipt. We encourage you to complete your registration as soon as possible. **Registration after 5:00 p.m. on October 12, 2007, will not be accepted.**

Meeting Participation Details

All persons attending the meeting in person will be required to show a photographic identification (a valid driver's license or passport). Further details can be found in the September 28, 2007 Federal Register Notice.

Additional Questions/Information

For questions or additional information about the Medicare Provider Feedback Town Hall Meeting, please send an email to MFG@cms.hhs.gov

I hope you enjoy a wonderful weekend ~ Valerie

Valerie A. Haugen Director

Division of Provider Information Planning & Development

Provider Communications Group, CMS

(410) 786-6690

Valerie.Haugen@cms.hhs.gov



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