

Provider Partnership Program (PPP) E-mail Notification Archives

May 2, 2007

A Few Items Related to Nursing Home and Home Health Services

CMS Proposes Increase In Medicare Payments To Nursing Homes For 2008

Medicare payments to nursing homes would increase by approximately \$690 million in fiscal 2008 under new rates recently proposed by the Centers for Medicare & Medicaid Services (CMS). This 3.3 percent increase would affect payment rates to nursing facilities that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems. The proposed rule for the skilled nursing facility prospective payment system (SNF PPS) was placed on display at the *Federal Register* on April 30, 2007

To see the CMS Press Release, please click on

http://www.cms.hhs.gov/apps/media/press_releases.asp.

To view the proposed rule, click on <http://www.cms.hhs.gov/SNFPPS/downloads/cms-1545-p-display.pdf>.

For further information about the SNF PPS, please click on

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

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CMS Issues Final Rule for Long-Term Care Hospitals for Rate Year 2008

On May 1, 2007, the Centers for Medicare & Medicaid Services issued the final rule titled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Final Annual Payment Rate Updates, and Policy Changes; and Final Hospital Direct and Indirect Graduate Medical Education Policy Changes" (CMS-1529-F). This final rule includes proposed payment rates and policy changes for hospitals paid under the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for the 2008 Rate Year.

This final rule also includes a change concerning Medicare Graduate Medical Education (GME) payments to teaching hospitals. The final rule modifies the rules concerning GME payments to teaching hospitals with respect to the time that residents spend training in non-hospital settings.

The display copy of the final rule can be viewed at

<http://www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-f.pdf>.

To view the CMS Press Release, click on

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2154>.

To view the CMS Fact Sheet, click on
<http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2155>.

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SNF/LTC Open Door Forum Updates

As was discussed at the **March 28, 2007 Skilled Nursing Facility-Long Term Care Open Door Forum**, Part B paid claims that overlap non-pay SNF claims are rejecting in error. On April 27, 2007 CMS released a change request that addresses the situation: Change Request Number 5587, Transmittal Number R274OTN, "Invalid Skilled Nursing Facility (SNF) Information Unsolicited Responses (IURs) from CWF." This CR can be found at the CMS website 2007 Transmittals page:

<http://www.cms.hhs.gov/Transmittals/2007Trans/list.asp?sortByDID=2a&filterType=none&filterByDID=-99&sortOrder=ascending&intNumPerPage=10&submit.x=7&submit.y=14>.

CMS has commissioned the CWF maintainer to create a program that will automatically identify the Part B claims that were erroneously rejected for the FIs, Part A MACs, MCS carriers, and DME MACs. The FISS maintainer has created an additional utility that will automatically adjust the Part B claims and reinstate the payment that was erroneously recouped. The FIs will be utilizing this program during the weekend of May 26th and 27th. The applicable providers will be able to view the corrected claims during the week of May 28th through June 1st and should expect payment shortly thereafter. Regarding the Part B MCS carriers and DME MACs, these contractors will be manually adjusting these claims now that CR 5587 has been released. The applicable providers will begin seeing these claims online and should expect to receive payment immediately thereafter. Part B providers are encouraged to allow the Medicare contractors to reprocess these claims and to not resubmit or adjust them in the meantime. If there are any questions or concerns relating to the timeframes in which these claims will be reprocessed, please contact the appropriate FI, carrier, or DME MAC.

Due to a conflict in the scheduling of the Medicare Fee-For-Service National Provider Identifier (NPI) Contingency Plan Roundtable that will be held on Thursday, May 10th at 2pm-3:30pm, EDT the SNF/LTC Open Door Forum has been rescheduled to 12:45pm-1:45pm, EDT to allow for participation in the NPI Roundtable.

Below is the revised participation information for the SNF/LTC Open Door Forum:

**Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum
(Conference Call Only)**

Date: May 10, 2007

Start Time: **12:45 PM** Eastern Daylight Time (EDT)

Conference Leader(s): Sheila Lambowitz/Jeff Flick/Natalie Highsmith

Open Door Forum Participation Instructions:

CMS Staff and Authorized Speakers Only

Dial: 1-877-792-5692

General Public

Dial: 1-800-837-1935

Reference Conference ID: 1885969

TTY Communications Relay Services are available for the Hearing Impaired. For TTY services 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.

ENCORE: 1-800-642-1687; Conf. ID# 1885969

Encore is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID. This will begin **Monday, May 14th** and will expire after 3 business days.

For Forum Schedule updates, Listserv registration and Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/opendoorforums>.

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CMS Proposes Payment Changes For Medicare Home Health Services

The Centers for Medicare & Medicaid Services (CMS) recently announced proposed changes to the Medicare Home Health Prospective Payment System (HH PPS) that will improve the accuracy of payments to home health agencies for services they furnish to Medicare beneficiaries. The display copy of the proposed rule is posted on the CMS website at: <http://www.cms.hhs.gov/HomeHealthPPS/downloads/CMS-1541-P.pdf>.

This rule includes a number of refinement proposals that will update the case-mix model to better reflect the current mix of home health patients, better reflect resources associated with certain type of episodes, and adjust for case mix creep. In addition, this rule proposes routine annual updates to the market basket, the fixed dollar loss ratio, and pay for reporting requirements. This update reflects the proposed home health market basket of 2.9 percent for Medicare payment rates for calendar year 2008 as well as a 2.75% reduction in the rates to account for nominal change in case-mix. The overall impact of the proposed refinements of this rule is estimated to increase total payments to home health agencies by approximately \$140 million in CY 2008. For more detailed information on the provisions of this proposed rule, refer to the HHA Fact Sheet <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2134>.

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MLN Matters article MM5551 – Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas has recently been posted at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5551.pdf>.

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

May 4, 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! Before I get to the news items for this week, I wanted to let you know that we have launched this year's Provider Partnership recruitment season, wherein we seek to enhance the already terrific list of national provider associations with whom we partner. So, if you have any suggestions for provider associations that are not yet Provider Partners, please feel free to let me know—thanks very much.

And now the news, including information on:

- National Provider Identifier (NPI) Roundtable Conference Call on May 10th
- Medicare Graduate Medical Education Payments to Teaching Hospitals
- Special Open Door Forum on Registry-based Reporting for the Physician Quality Reporting Initiative (PQRI)
- Proposed Payment, Policy Changes for Inpatient Rehabilitation Facilities in FY 2008
- May is Healthy Vision Month
- Updates from the Medicare Learning Network

- **Federal Health Leaders to Launch New Prevention Campaign**

NPI: Get It. Share It. Use It.

REMINDER – Medicare Fee-For-Service (FFS) NPI Contingency Plan Roundtable on May 10th

CMS will host a National Roundtable on the recently released Medicare FFS NPI Contingency Plan. This toll-free call will take place from 2:00 p.m. – 3:30p.m., EDT, on Thursday, May 10, 2007. Visit

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIRoundTable.pdf> for more details and registration information. **Registration will close at 2:00 p.m. EST on May 9, 2007**, or when available space has been filled. No exceptions will be made, so register today!

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://npes.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.

Medicare Graduate Medical Education Payments to Teaching Hospitals

On May 1, 2007, the Centers for Medicare & Medicaid Services finalized a change concerning Medicare Graduate Medical Education (GME) payments to teaching hospitals. The change is included in a final rule titled “Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Final Annual Payment Rate Updates, and Policy Changes; and Final Hospital Direct and Indirect Graduate Medical Education Policy Changes.” The final rule modifies the rules concerning GME payments to teaching hospitals with respect to the time that residents spend training in non-hospital settings. *CMS has also posted the 2006 American Medical Group Association (AMGA) Compensation Survey Data on its website.* To view the final rule, the section on GME payments, and the 2006 AMGA compensation data, click on the following link:

http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp#TopOfPage.

Special Open Door Forum on Registry-based Reporting for the Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on the use of registries for reporting data on quality measures to the Physician Quality Reporting Initiative (PQRI).

This Special Open Door Forum will take place from **1:00 p.m. – 5:00 p.m., EDT**, on **Monday, May 14, 2007** in the CMS auditorium, 7500 Security Blvd., Baltimore, MD. A toll-free number will be available for those who will participate by telephone.

Division B, Title 1-Medicare Improved Quality and Provider Payments, Section 101 (b) of the Tax Relief and Health Care Act (TRHCA) of 2006, states that "As part of the publication of proposed and final quality measures for 2008..., the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database), as identified by the Secretary." This Special Open Door Forum will build on the broad overview of the 2007 PQRI program presented on two recent national provider conference calls by giving providers and organizations that use or produce registries and other members of the public the opportunity to discuss the potential use of registries for reporting data on quality measures to PQRI.

For the most up to date information on PQRI, please visit www.cms.hhs.gov/PQRI.

To participate in the Special Open Door Forum in person or by phone, you will need to register on this web site: <http://registration.intercall.com/go/cms2>

Registration will close at **4:00 p.m. EDT on Wednesday May 9, 2007**. Please be sure to register prior to this time.

For those who will be unable to attend, the Special Open Door Forum will be recorded. A replay option will be available beginning the close of business May 18, 2007 and will be accessible for 3 days. You may visit the following website <http://www.cms.hhs.gov/center/hospital.asp> to download an audio recording.

If you have questions or require special accommodations, please contact Diane Stern at diane.stern@cms.hhs.gov at (410) 786-1133.

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CMS PROPOSES PAYMENT, POLICY CHANGES FOR INPATIENT REHABILITATION FACILITIES IN FISCAL YEAR 2008

Inpatient rehabilitation facilities (IRFs) are projected to receive approximately \$6.3 billion in payments from the Medicare program in fiscal year (FY) 2008, under a proposed rule announced today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule would update payment rates and modify payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007 through September 30, 2008. The rule's provisions are estimated to increase

Medicare payments to approximately 1,234 IRFs in FY 2008 by approximately \$150 million.

To view the Press Release, please click here:

http://www.cms.hhs.gov/apps/media/press_releases.asp

May is Healthy Vision Month

Please join the Centers for Medicare & Medicaid Services (CMS) and the National Eye Institute (NEI) in promoting increased awareness of glaucoma and the glaucoma screening benefit provided by Medicare. An estimated 2.2 million Americans have been diagnosed with primary open-angle glaucoma, the most common form of the disease. An additional 2 million Americans have glaucoma and don't even know it. Glaucoma has no warning signs and, if left untreated, can result in permanent vision loss. If glaucoma is detected early, there is treatment available to slow or stop vision loss and reduce the risk of blindness.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma;
- African-Americans age 50 and older; and
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

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 needs your help to ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit. Talk to your Medicare patients that are in the high risk groups identified above about their risk for glaucoma and encourage them to get regular yearly glaucoma screening examinations.

For More Information

- For more information about Medicare's coverage of glaucoma screening, visit the CMS website <http://www.cms.hhs.gov/GlaucomaScreening/>
- 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.
- The CMS website provides information for each preventive service covered by Medicare. Go to www.cms.hhs.gov, select “Medicare”, scroll down to the “Prevention” heading.
- For information to share with your Medicare patients, please visit <http://www.nei.nih.gov/glaucomaeducation> and <http://www.nei.nih.gov/glaucoma/>.
- For more information about Healthy Vision Month, please visit <http://healthyvision2010.nei.nih.gov/hvm/>.

Help your at-risk patients protect their vision. Encourage regular annual glaucoma screenings.

Updates from the Medicare Learning Network

MLN Matters Articles ~

Revised:

SE0713 – Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf>

Provider Types Affected: All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS program.

MM5595 – Medicare Fee-For-Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>

Provider Types Affected: Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), Durable Medical Equipment Regional Carriers (DMERCs), and DME Medicare Administrative Contractors (DME MACs))

Other MLN Products ~

Revised errata sheets and downloadable versions (April 2007) of the **Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals and the Facilitator's Guide** – *Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* have been posted on the Centers for Medicare & Medicaid Services Medicare Learning Network. To access these publications, visit www.cms.hhs.gov/MLNProducts/MPUB/list.asp.

The revised (March 2007) **Medicare Disproportionate Share Hospital Fact Sheet**, which provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment and Medicare DSH payment adjustment formulas, is now available on the Centers for Medicare & Medicaid Services Medicare Learning Network at www.cms.hhs.gov/MLNProducts/downloads/2007mdsh.pdf. Print versions of the fact sheet will be available in approximately six weeks.

**MEDICARE NEWS
FOR IMMEDIATE RELEASE**

April 20, 2007

FEDERAL HEALTH LEADERS TO LAUNCH NEW PREVENTION CAMPAIGN

“A Healthier US Starts Here” Tour to Promote Prevention; Healthier Living
the U.S. Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS), joined by other Administration officials as well as leaders from national disease management and health care advocacy organizations, recently launched “A Healthier US Starts Here,” tour to motivate seniors and others with Medicare to make the most of Medicare’s preventive services.

Over the next four months, the tour will visit each of the 48 continental states to promote preventive services with Medicare beneficiaries, families, caregivers, health professionals, community organizations, civic and state leaders and others who want to help people live longer, healthier lives.

“A Healthier US Starts Here” tour will also teach people how to make the most of a special prevention-targeted CMS website, MyMedicare.gov -- a one-stop, user-friendly website that gives registered Medicare users access to personalized information on benefits and services.

For more information click the CMS Website

located: http://www.cms.hhs.gov/MyHealthMyMedicare/02_HealthierUS.asp

Once you click here, CMS provides you with a toolkit (see Downloads section) that includes publications, training materials and a video loop so that we can work together to ensure that "A Healthier US Starts Here!"

To view the HHS Release issued today click here:

<http://www.hhs.gov/news/press/2007pres/04/pr20070420a.html>

I hope everyone enjoys a wonderful weekend ~ Valerie

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

May 9, 2007

REMINDER: Medicare FFS NPI Contingency Plan Roundtable on
Thursday, May 10th

NPI: Get It. Share It. Use It.

REMINDER – Medicare Fee-For-Service (FFS) NPI Contingency Plan Roundtable on May 10th

CMS will host a National Roundtable on the recently released Medicare FFS NPI Contingency Plan. This toll-free call will take place from **2:00 p.m. – 3:30p.m., EDT, on Thursday, May 10, 2007**. Visit <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIRoundTable.pdf> for more details and registration information. **Registration will close at 2:00 p.m. EDT on May 9, 2007**, or when available space has been filled. No exceptions will be made, so register today!

Once you have registered, please plan to call in to the Roundtable 10 minutes early so that you are on the line when the presentation begins.

Transcript for 4/18/07 NPI Roundtable Now Available

The transcript for the NPI Roundtable on the Contingency Guidance is now posted at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/April18_Roundtable_Transcript.pdf on the NPI page.

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.***

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

May 11, 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!

Hello everyone ~ just three items for you today:

- **Registration for the May 14, 2007 Special Open Door Forum on Registry-based Reporting for PQRI is now closed.**
- **Encore Presentation for the May 10th National Provider Identifier (NPI) Roundtable Conference Call is now available.**
- **Updates from the Medicare Learning Network**

Registration for the May 14, 2007 Special Open Door Forum on Registry-based Reporting for PQRI is now closed. If you were intending to present a three minute prepared statement, we are very interested in your comments. Please send your comments to Stephanie Peterson [SPeterson@Mathematica-Mpr.com] by close of business May 14, 2007.

Please check the “CMS Sponsored Calls” section of the PQRI web page at, <http://www.cms.hhs.gov/pqri>, for the agenda, slide presentations and other related documents that will be used at the May 14, 2007 Special Open Door Forum.

You may visit the following website, <http://www.cms.hhs.gov/center/hospital.asp>, to download an audio recording of the Special Open Door Forum on Registry-Based Reporting. *The audio will be available beginning the close of business May 18, 2007 EDT and will be accessible for three business days.*

Thank you for your interest in the Special Open Door Forum on Registry-based Reporting for PQRI.

NPI: Get It. Share It. Use It.

Encore Presentation for May 10th NPI Roundtable

An Encore presentation will be available for the May 10th Roundtable on the Medicare FFS NPI Contingency Plan. The Encore will be accessible from 5:30 p.m. EDT on 05/10/2007 until 05/17/2007, 11:59 p.m. EDT.

The call-in number for the Encore is (800) 642-1687 and the pass code is 7087149. A transcript will be posted on the NPI web page within two weeks of the call.

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/NationalProviderIdentifierStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

Updates from the Medicare Learning Network

Here are some recently-released MLN Matters articles that I thought would be of interest to you:

New:

SE0721 – Provider Authentication Requirements for Telephone and Written Inquires during the Medicare FFS National Provider Identifier (NPI) Contingency Plan

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf>

Provider Types Affected: All physicians, suppliers, and providers who call or write their Medicare Fee-for-Service (FFS) contractors (Fiscal intermediaries (FIs), Carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), DME Regional Carriers (DMERCs) and/or Regional Home Health Intermediaries (RHHIs) with general inquiries.

Revised:

SE0712 – Common Billing Errors to Avoid when Billing Medicare Carriers

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0712.pdf>

Provider Types Affected: Physicians and providers billing Medicare carriers for services provided to Medicare beneficiaries

MM5571 – New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFS) for Claims Processing

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5571.pdf>

Provider Types Affected: Physicians (when ordering DMEPOS) and suppliers using CMNs and DIFs when billing to Medicare durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative contractors (DME/MACs).

MM5060 – Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5060.pdf>

Provider Types Affected: Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

MM4239 – Claims Submission Instructions for Institutional Providers Billing Vaccine Claims in Cases Where a National Provider Identifier (NPI) Is Not Available

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4239.pdf>

Provider Types Affected: Institutional providers submit affected claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

I hope you have a great weekend!

With best regards ~ Valerie

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

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

May 14, 2007

May 13-19, 2007 is National Women's Health Week

The Centers for Medicare & Medicaid Services (CMS) would like to invite you to join us in recognizing ***National Women's Health Week***. This annual health observance is a perfect opportunity to help women learn how they can live longer, better, healthier lives through the promotion of disease prevention, early detection and lifestyle modifications that support a healthier life.

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well being of women in the US. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help women stay healthy, detect disease early and manage conditions to reduce complications. Medicare-covered preventive benefits include:

Abdominal Aortic Aneurysm Screening (new as of January 2007)

Adult Immunizations

- Flu
- Pneumococcal
- Hepatitis B.

Cancer Screenings

- Breast (mammogram and clinical breast exam)
- Cervical & Vaginal (Pap test and pelvic exam)
- Colorectal

Cardiovascular Screening

Diabetes Screening

Diabetes Supplies

Diabetes Self-management Training

Glaucoma Screening

Initial Preventive Physical Exam (“Welcome to Medicare” Physical Exam)

Medical Nutrition Therapy (beneficiaries with diabetes or renal disease)

Smoking and Tobacco-Use Cessation Counseling

Although Medicare is now helping to pay for more preventive benefits, many women with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. With your help we can begin to close the prevention gap.

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing women’s use of Medicare preventive benefits. We need your help to ensure that women with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

For Women Patients New to Medicare ~ When appropriate, provide the *Welcome to Medicare* physical exam. This one time exam, which must be received within the first 6 months of a beneficiary’s Medicare Part B effective date, is an excellent opportunity to orient new women patients to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive benefits through referral for appropriate services. Remember to follow-up with patients on all screening results, even negative ones — every one likes to hear good news.

For Established Patients ~ Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible and provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

Working together we can begin to:

- educate women about steps they can take to prevent disease;
- increase awareness of risk factor for developing disease while promoting prevention, early detection and treatment of disease affecting women’s health;
- prevent and reduce serious complications of disease through better disease management;
- reduce mortality for many diseases effecting women;

- improve the health and quality of life of women;
- ensure that women with Medicare take advantage of preventive benefits they may be eligible for, before they become sick; and
- ultimately save health care dollars.

For More Information

For more information about Medicare-covered preventive services and screenings, including coverage, coding and billing guidelines, please visit the following CMS website:

- The MLN Preventive Services Educational Products Web Page
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage

For products to share with your Medicare patients go to www.medicare.gov

To learn more about National Women's Health Week, please visit <http://www.4woman.gov/whw/>

Thank you for joining with CMS to spread the message about prevention, early detection and treatment.

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

May 15, 2007

BIDDING FOR DMEPOS IS OPEN!

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. **All bids are due by 9:00 p.m. prevailing Eastern Time on July 13, 2007.** The contract period for mail order diabetic supplies is April 1, 2008 – December 31, 2009. The contract period for all other first round product categories is April 1, 2008 – March 31, 2011.

The first round competitive bidding areas (CBAs) and product categories were announced on April 2, 2007. CMS has issued for each CBA a detailed chart providing

important bidding information for suppliers. Suppliers should use these charts when preparing their bids. Bidders will submit their bids using an internet-based bid submission system. The CBAs, product categories, bidding information charts, and full instructions for submitting a bid are located on the Competitive Bidding Implementation Contractor (CBIC) web site: www.dmecompetitivebid.com

Suppliers interested in bidding must first register and receive a User ID and Password before they can access the internet-based bid submission system. Suppliers should register immediately to avoid a delay in being able to submit bids. **The registration deadline is June 30, 2007.** For information on how to register and bid, visit: www.dmecompetitivebid.com

Also, in order to participate in the program, suppliers must meet quality standards and be accredited by a Centers for Medicare & Medicaid Services (CMS)-approved Deemed Accreditation Organization. Suppliers must be accredited or be pending accreditation to submit a bid. **The accreditation deadline for the first round of competitive bidding is August 31, 2007.** Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. For a list of the CMS-approved Deemed Accreditation Organizations, visit: <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>

The CMS and the CBIC have issued important supplier educational materials, including a supplier tool kit, fact sheets, web-cast, and "frequently-asked questions" (FAQs). To access these materials, visit: www.dmecompetitivebid.com

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

PQRI Updates and Highlights

Third National Provider Conference Call

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the third 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. – 3:00 p.m., EST, on Thursday, May 24th, 2007.

This call will provide detailed information about how to select and implement PQRI measures in clinical practice, and facilitate successful reporting. The presentation will discuss how eligible professionals can:

- Identify eligible cases based on ICD-9-CM and CPT Category I codes;
- Choose the correct quality-data codes to report;
- Know when to use “exclusion” modifiers (i.e., 1P, 2P, and 3P); and
- Know when to use a reporting modifier (i.e., 8P).

Materials for the call will be posted to the PQRI webpage at, <http://www.cms.hhs.gov/PQRI>, on the CMS website in the Educational Resources section for you to download prior to the call so that you can follow along with the presenters, Dr. Thomas Valuck and Dr. Susan Nedza.

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

Conference call details:

Date: May 24, 2007
Conference Title: 2007 Physician Quality Reporting Initiative on Coding Guidance
Time: 1:30-3:00 p.m. EST

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, an Encore feature will be made available and the replay information can be found below.

Registration will close at 1:30 p.m. EST on May 23, 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/052407>

2. Fill in all required data.
3. Click "Register".
4. 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 be found 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 05/24/2007 until 05/31/2007, 11:59 p.m. EST. The call-in data for the replay is (800) 642-1687 and the passcode is 8896727.

Online Evaluation Form:

CMS has developed an online evaluation form that can be quickly completed and submitted. Participants are asked to complete this form to help CMS make informed decisions on improving training activities. The online evaluation form titled "Medicare Training Evaluation Form" can be found on the registration page, http://www.cms.hhs.gov/MLNProducts/60_ContractorTraining.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.

Three New Frequently Asked Questions (FAQ)

Three new FAQs were recently added to the CMS web page on PQRI. These FAQs address how CMS will calculate the single national average measure payment amount, information about reporting non-compliance, and information related to physical therapy claims. Visit <http://www.cms.hhs.gov/PQRI> and click on "All FAQs" to access the FAQs from any page.

Question of the Week

Question: What are the financial benefits of participation in the Physician Quality Reporting Initiative (PQRI)?

Answer: PQRI participant who reports successfully will be eligible for a lump-sum bonus payment of up to 1.5 percent of the Medicare Physician Fee Schedule allowed charges for services provided during the reporting period, subject to a cap, as established by the Tax Relief and Health Care Act of 2006 (TRHCA).

Reference: <http://www.cms.hhs.gov/PQRI>.

*Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
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CMS Announces Testing Opportunity for the 2007 PQRI

Testing Opportunity for the Physician Quality Reporting Initiative

Eligible professionals interested in testing their billing system, and practice their readiness for PQRI quality data code reporting, will have a chance to do so. CMS has designated “G8300” as a test code for PQRI reporting prior to July 1, 2007, the start date for PQRI reporting. G8300 was formerly used in the 2006 PVRP program and will be retired on July 1, 2007; meaning it will be rejected on any claims submitted for dates of service on and after July 1, 2007. In the interim, it can be used to test readiness as follows:

1. Add the G8300 test code as a line item on any claims for services. On the ASC X12N health care claim transaction (version 4010A1), submit the HCPCS code G8300 in the SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

For claims submitted on the CMS 1500 Form, report the test code in field 24D.

2. Randomly enter “\$0.00 or “\$0.01” as the line item charge for the test code. This will confirm the ability of billing software or clearinghouses to accept either.

3. Check your Remittance Advice (RA) for these claims to assure the test code has been passed through and processed by the carrier or MAC. You should see Claim Adjustment Reason Code message 96, “Non-covered charge(s).” Also, you will see Remittance Advice Remark Code message N365, “This procedure code is not payable. It is for reporting/information purposes only.” The RA will serve as your feedback for the test. CMS will not issue any other feedback.

4. The RA will indicate that the test code was denied. The test code will also show up on the beneficiary's MSN with the statement "This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount." This same message will be appear on MSNs during the 2007 PQRI reporting period for designated 2007 PQRI codes.

Though eligible professionals are free to test until July 1, CMS will be conducting some back end testing in June, so to the extent possible, we ask that eligible professionals submit some claims with the PQRI test codes as described above prior to May 30, 2007.

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

May 18, 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! Today's news items include information on:

- **CMS Releases FY 2008 Hospital Inpatient Prospective Payment System Proposed Rule**
- **Correction to LTCH PPS Final Rule**
- **More Patients Likely to Ask About Medicare Prevention Benefits**
- **Reminder ~ Testing Opportunity for the PQRI**
- **Special ODF Regarding Notification of Hospital Discharge Appeal Rights**
- **Updates from the Medicare Learning Network**

CMS Releases FY 2008 Hospital Inpatient Prospective Payment System Proposed Rule

On April 13, 2007, the Centers for Medicare & Medicaid Services (CMS) issued the FY 2008 hospital inpatient prospective payment system (IPPS) proposed rule (CMS-1533-P). The FY 2008 IPPS proposed rule appeared in the May 3, 2007 issue of the *Federal Register*. CMS recently discovered an error that was made in the calculation of the DRG relative weights in the FY 2008 IPPS proposed rule. CMS revised the relative weights to correct the error and recalculated the IPPS standardized amounts. The changes will increase the IPPS standardized amounts by \$0.18. Other information in the IPPS proposed rule will also be affected. The proposed FY 2008 outlier threshold will decrease by \$85 to \$22,940. There will also be some minor changes to the wage index in the 4th decimal place for some hospitals. CMS has posted new tables (Tables 1A-1D, Table 2 and Table 4J, Table 5, new payment impact files, new DRG cost and charge weights file) on the CMS web site. We also expect to publish a correction notice with the revised information in the *Federal Register* shortly. Please go to the following web pages for revised FY 2008 IPPS rule information (click to sort the Fiscal Year column in descending order):

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

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

Correction to LTCH PPS Final Rule

On May 1, 2007, the Centers for Medicare & Medicaid Services (CMS) posted the RY 2008 long term care hospital prospective payment system (LTCH PPS) final rule (CMS-1529-F) and it appeared in the May 11, 2007 issue of the *Federal Register*. CMS recently discovered an error that was made in the calculation of the high cost outlier fixed-loss amount in the RY 2008 LTCH PPS final rule. The final RY 2008 high cost outlier fixed-loss amount should have been **\$20,738**. We expect to publish a correction notice with the revised information in the *Federal Register* shortly.

More Patients Likely to Ask About Medicare Prevention Benefits

The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have launched *A Healthier US Starts Here* campaign, which is an initiative focused on motivating seniors and others with Medicare to make the most of Medicare's prevention services and maintaining healthy lifestyles.

Throughout 2007 there will be events and programs designed to promote conversations between people with Medicare, families, caregivers, health professionals, and community organizations about prevention services that Medicare covers to help keep beneficiaries healthy.

“Preventive health care can help people live healthier lives and can help reduce costs associated with treating chronic disease. From Seattle to Miami and Boston to San Diego, *A Healthier US Starts Here* will enlist the support of local organizations to help Medicare beneficiaries and all Americans learn how to live longer, healthier, and happier lives,” HHS Secretary Mike Leavitt said.

Our message to people with Medicare is clear: “talk to your doctor to see what services are right for you.” Therefore, we anticipate that clinicians will be hearing from their patients about Medicare-covered prevention benefits and we wanted to provide you with information about correct coding for these services. Here is a link to a copy of the brochure that offers a checklist of the Medicare-covered preventive services:

<http://www.medicare.gov/Publications/Pubs/pdf/11308.pdf>.

Medicare currently covers:

- A one time “Welcome to Medicare” physical (including an abdominal aortic aneurysm screening for qualifying individuals)
- Cardiovascular screenings
- Cancer tests – mammogram breast cancer screening, pap test and pelvic exam cancer screenings, colorectal cancer screenings, and prostate cancer screening
- Shots and vaccines – flu, Pneumococcal, Hepatitis B
- Bone mass measurement
- Diabetes screening, glucose monitoring supplies, and self-management training
- Medical nutrition therapy for people with diabetes or kidney disease
- Glaucoma test
- Smoking cessation counseling

CMS has also developed a quick reference chart that provides the codes for your office staff to use in billing for preventive services. To download, view and print a copy of the quick reference chart, go to

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

You can also go to www.cms.hhs.gov/healthierUS for a copy of a comprehensive toolkit that includes information for patients. You can also get information about coverage, coding and billing of Medicare-covered preventive services from the Medicare Learning Network Preventive Services Educational Products web page located at

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

The prevention initiative will also encourage people to use the CMS website, www.mymedicare.gov. This is a one-stop, user-friendly website that gives registered Medicare users access to personalized information on benefits and services that are available to them. When beneficiaries log on, they can check which preventive benefits they need; check their Part B deductible status; view eligibility and enrollment information – including for the Part D prescription drug program; and take care of administrative issues such as verifying an address, ordering replacement Medicare cards, check on the status of claims, and get on-line forms and publications. People with Medicare can also get this same information by calling 1-800-MEDICARE.

We hope that you will work with us to help people make the most of their Medicare. By educating your patients about the Medicare covered preventive services that are right for them, we can make sure that a healthier US starts here!

Testing Opportunity for the Physician Quality Reporting Initiative

Eligible professionals interested in testing their billing system, and practice their readiness for PQRI quality data code reporting, will have a chance to do so. CMS has designated “G8300” as a test code for PQRI reporting prior to July 1, 2007, the start date for PQRI reporting. G8300 was formerly used in the 2006 PVRP program and will be retired on July 1, 2007; meaning it will be rejected on any claims submitted for dates of service on and after July 1, 2007. In the interim, it can be used to test readiness as follows:

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4. The RA will indicate that the test code was denied. The test code will also show up on the beneficiary’s MSN with the statement “This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount.” This same message will be appear on MSNs during the 2007 PQRI reporting period for designated 2007 PQRI codes.

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Special Open Door Forum:

Notification of Hospital Discharge Appeal Rights:
The Important Message from Medicare and the Detailed Notice of Discharge

Tuesday, May 29, 2007

2:00 – 3:00 PM EDT

(Conference Call Only)

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on CMS-4105-F, Notification of Hospital Discharge Appeal Rights, and the associated notices. This final rule sets forth requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Notice is required for both original Medicare beneficiaries and beneficiaries enrolled in Medicare health plans. The regulation is effective July 2, 2007.

To participate:

CMS Staff & Authorized Speakers

Dial: 1-877-792-5692

General Public

Dial: 1-800-837-1935

Reference Conference ID: 7588715

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services 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.

ENCORE: 1-800-642-1687; Conf. ID# **7588715**

"Encore" is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conference ID beginning on 2 hours after the call ends. The recording will expire after 4 business days.

For Forum Schedule updates, Listserv registration and Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/OpenDoorForums/>

Updates from the Medicare Learning Network

New Special Edition MLN Matters Article Released: SE0714 – Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0714.pdf>

Provider Types Affected: All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS competitive bidding program.

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The downloadable version of the ***Inpatient Psychiatric Facility Prospective Payment System Fact Sheet***, which has been revised to include information about the Rate Year 2008 updates, is now available on the **Medicare Learning Network** at <http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.pdf>. The fact sheet also provides general information about the Inpatient Psychiatric Facility Prospective Payment System and how payment rates are set. The print version of the fact sheet will be available in approximately six weeks.

Hope everyone has a great weekend!

With best regards ~ Valerie

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

Update to Information Regarding Medicare Payment and Coding for Drugs and Biologicals

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, we have also reviewed how we have operationalized the terms “single source drug,” “multiple source drug,” and “biological product” in the context of payment under section 1847A. For the purposes of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. We will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the

applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be operationalized through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes. Examples of how we are operationalizing this approach using unique HCPCS codes include: (1) the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007, and (2) the series of Q codes for immune globulin and the new Q code for Reclast® effective July 1, 2007.

Section 1847A requires single source drugs or biologicals that were within the same billing and payment code as of October 1, 2003, be treated as multiple source drugs, so the payment under Section 1847A for these drugs and biologicals is based on the volume weighted average of the pricing information for all of the products within the billing and payment code. We are working to ensure that payments accurately reflect this "grandfathering" provision. Examples of how we are operationalizing this provision include: (1) Q4083 for Hyalgan and Supartz effective January 1, 2007, and (2) Q4094 for albuterol and levalbuterol and Q4093 for concentrated forms of albuterol and levalbuterol effective July 1, 2007.

In addition, appropriate modifications of the NDC to HCPCS crosswalk used to calculate the payment limits for purposes of Section 1847A will be made to ensure that payment will be based on the pricing information for all products produced or distributed under an FDA approval for the drug or biological. One result is the same payment limit for J0885 (injection, epoetin alfa, (for non-ESRD use)) and J0886 (injection, epoetin alfa, (for ESRD on dialysis)).

We will continue to work to identify and implement payment and coding changes as necessary to ensure more accurate payments under Section 1847A. So that we can implement any further necessary changes during 2007, we will continue to use our internal process for modifying the HCPCS code set and for adjusting the NDC to HCPCS crosswalk.

A full list of the July 2007 quarterly updates to the HCPCS is available at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage

Pricing information for Part B drugs and biologicals for the third quarter of 2007 (July 1 – September 30) will be posted on or after June 15th at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage

The announcement for the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007 and Q4083 for Hyalgan and Supartz also effective January 1, 2007, was posted on December 22, 2006 and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf>

*Aryeh Langer for Valerie A.
Hart,*

*Director Division of Provider Information
Planning & Development
Provider Communications Group, CMS*

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

May 22, 2007

Physician Quality Reporting Initiative News

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

This is a reminder that the Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the third 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. – 3:00 p.m., EST, on Thursday, May 24th, 2007.

This call will provide detailed information about how to select and implement PQRI measures in clinical practice, and facilitate successful reporting. The presentation will discuss how eligible professionals can:

- Identify eligible cases based on ICD-9-CM and CPT Category I codes;
- Choose the correct quality-data codes to report;
- Know when to use “exclusion” modifiers (i.e., 1P, 2P, and 3P); and
- Know when to use a reporting modifier (i.e., 8P).

Materials for the call will be posted to the PQRI webpage at, <http://www.cms.hhs.gov/PQRI>, on the CMS website in the Educational Resources section for you to download prior to the call so that you can follow along with the presenters, Dr. Thomas Valuck and Dr. Susan Nedza.

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

Conference call details:

Date: May 24, 2007
Conference Title: 2007 Physician Quality Reporting Initiative on Coding Guidance
Time: 1:30-3:00 p.m. EST

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, an Encore feature will be made available and the replay information can be found below.

Registration will close at 1:30 p.m. EST on May 23, 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/052407>
2. Fill in all required data.
3. Click "Register".
4. 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 be found 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 05/24/2007 until 05/31/2007, 11:59 p.m. EST. The call-in data for the replay is (800) 642-1687 and the passcode is 8896727.

Online Evaluation Form:

CMS has developed an online evaluation form that can be quickly completed and submitted. Participants are asked to complete this form to help CMS make informed decisions on improving training activities. The online evaluation form titled "Medicare Training Evaluation Form" can be found on the registration page, http://www.cms.hhs.gov/MLNProducts/60_ContractorTraining.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.

Question of the Week

Question: Is registration required for participation in the Physician Quality Reporting Initiative (PQRI)?

Answer: No. Registration is not required in order to participate in the 2007 PQRI. To participate in the 2007, PQRI physicians and other eligible professionals, as defined by the Tax Relief and Health Care Act of 2006 (TRHCA), should begin by reviewing the detailed 2007 PQRI Quality Measure Specifications and related informational materials available on the CMS PQRI website (<http://www.cms.hhs.gov/pqri>), and selecting measures applicable to their practice and the conditions that they treat. The eligible professionals should then report the selected measures by submitting the specified quality-data codes as line items on claims for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007.

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

An additional election period for physicians who are not currently participating in the Competitive Acquisition Program (CAP) is underway. 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 began on May 1, 2007 and will 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, including new educational materials about the physician election process are 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.

*Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
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May 23, 2007

Announcement of Transcript/Audio for PQRI Registry Session

Written Transcript and Audio Files for the **May 14th, 2007** Physician Quality Reporting Initiative (PQRI) Special Open Door Forum on Registry-based Reporting is now available on the PQRI web page. We apologize for the delay in posting this material.

To access the written transcript, visit <http://www.cms.hhs.gov/PQRI> on the CMS website and click on the CMS Sponsored Calls tab. Once on the CMS Sponsored Calls page, scroll down to the "Downloads" section and click on the "**Transcript for May 14 Special Open Door Forum**" link.

To access the audio file, visit <http://www.cms.hhs.gov/PQRI> on the CMS website and click on the CMS Sponsored Calls tab. Once on the CMS Sponsored Calls

page, scroll down to the "Related Links Inside CMS" section and click on the "Audio File-May 14th, 2007 Special Open Door Forum parts 1&2" links.

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

NPI: Get It. Share It. Use It.

The NPI Compliance Deadline is Here!

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. Please review the April 2, 2007 CMS "**Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule.**" As this guidance pertains to claims transactions, it means that:

1. Providers must have and use their NPI;
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2. Aware that health plans may lift their contingency plans (and require an NPI on claims or other HIPAA transactions) any time before May 23, 2008.
3. Working with vendors and clearinghouses with whom they contract, to make sure the NPI is being passed to health plans.
4. Paying close attention to how and when health plans will be testing implementation of the NPI.
5. Aware that, for those health plans that did not establish a contingency plan, providers are required to use their NPIs now. This means that if you are not using your NPI, your claim may be rejected or denied.

New Tip Sheet Available

A Tip sheet entitled ***What the “Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule” Means for Health Care Providers*** is now available at

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/ContingencyTipSheet.pdf>

This product provides helpful steps for providers based on the contingency guidance released on April 2, 2007. This guidance does not mean that providers have an extra year to get an NPI, so please view the Tip Sheet for additional information.

Reminder – Sharing NPIs

Once providers have received their NPIs, they should share them with other providers with whom they do business, and with health plans that request them. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that request them for use in standard transactions -- including those who need to identify ordering or referring physicians/providers. Providers should also consider letting health plans, or institutions for whom they work (e.g. a large hospital system), share their NPIs for them.

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- Lost NPI notification letter
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- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

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CustomerService@NPIenumerator.com.

Resources for other kinds of questions can be found at the end of this document.

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Important Information for Medicare Fee-For-Service (FFS) Providers

Testing Medicare Claims

To date, Medicare has encouraged providers to submit both an NPI and a legacy identifier on claims. Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. If any claim is rejected, the NPI should be verified to make sure it was entered correctly. If the NPI is correct, then data in either NPES or Medicare provider files should be corrected. The following fields in your NPES and/or 855 provider enrollment record should be validated:

- EIN (for organization providers)
- Other Provider Identification Numbers. This is where providers, when they apply for their NPIs, list the Medicare legacy identifier(s) that needs to be linked to the NPI.
- Practice Location Address
- Master Address (from provider enrollment records)
- Other Address (from provider enrollment records)

- Legal Name or Legal Business Name

Once this has been done, test again with a small number of claims. This process will help establish confidence that your claims will be paid. It is critical that you start testing with your NPI now.

While Medicare FFS has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

Reminder - Medicare FFS Contingency Plan Announced on April 24th

View the associated Change Request at <http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf>, as well as the related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website. These materials were recently revised; please be sure to visit the links above for the latest information.

Reminder - NPI MLN Matters Articles

There are many MLN Matters articles dealing with various topics of NPI relative to the Medicare program. These MLN articles are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_npi.pdf

Additional Information

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.

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

Materials for May 24, 2007 PQRI National Provider Call

Physician Quality Reporting Initiative (PQRI) National Provider Call- May 24, 2007

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the materials to be used during the May 24th, 2007 National Provider Call has been posted to the CMS website.

The meeting materials are as follows:

1. 2007 Physician Quality Reporting Initiative (PQRI) PowerPoint Presentation on Coding Guidance- Module III, May 24, 2007
2. **Change Request (CR) 5640 - Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles**
3. **MLN Matters Article – MM5640**

To access the meeting materials, visit <http://www.cms.hhs.gov/PQRI> on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section and click on the **“Materials for PQRI National Provider Call, May 24, 2007”** link. As an added benefit, the presentation is also available as an Adobe Acrobat file.

Question of the Week

Question: What are the financial benefits of participation in the Physician Quality Reporting Initiative (PQRI)?

Answer: A PQRI participant who reports successfully will be eligible for a lump-sum bonus payment of up to 1.5 percent of the Medicare Physician Fee Schedule allowed charges for services provided during the reporting period, subject to a cap, as established by the Tax Relief and Health Care Act of 2006 (TRHCA).

Reference: <http://www.cms.hhs.gov/PQRI>.

*Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
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Mailstop C4-11-27
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Bidders Conferences for the Medicare DMEPOS Competitive Bidding Program

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The Centers for Medicare & Medicaid Services (CMS) invites you to participate in a series of DMEPOS Competitive Bidding Program Bidders Conferences. These conferences will be conducted via teleconference and will provide you the opportunity to learn more about the program. Each call will last approximately one hour, including time for questions and answers.

1. *Submitting Your Bid* - Monday, June 4, 2007, 2 pm EST

This call will guide you through the Competitive Bidding Submission System and assist you in navigating the system.

2. *Understanding the Bidding Rules* - Wednesday, June 6, 2007, 2 pm EST

During this call, we will discuss issues such as common ownership, the types of financial documents that must be submitted as part of your application, small business provisions, the bidding evaluation process and time frames.

3. *Product Categories* - Friday, June 8, 2007, 2 pm EST

Topics that will be discussed include how product categories were selected, what constitutes the mail order diabetic testing supplies category, and what is included in the grandfathering provisions.

There is no charge for these teleconferences. To register, please go to the Competitive Bidding Program website at <http://www.dmecompetitivebid.com>. You may submit your questions ahead of time when you register to attend one or more events. More information about the teleconference calls, including the call-in number and confirmed date and time, will be sent to you upon registration. In addition, an audio recording and transcripts will be available on the website after each teleconference. If you have any questions, please call the Competitive Bidding Program Service Center toll-free at 877-577-5331.

*Valerie A. Hart, Director
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Provider Communications Group, CMS
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May 24, 2007

Hospital Discharge Appeal Notices

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Manual instructions should be posted on this page within the next week. These instructions will be located in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 30, Section 200.

We will also be posting a Power Point for participants to use during the Special Open Door Forum on Tuesday May 29, 2007.

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May 25, 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! I sent several individual messages throughout this week because of timeliness concerns. For your convenience, I am including those messages,

along with a couple of new items, in today's e-mail. The result is a collection of information on:

- **Physician Quality Reporting Initiative** *(contains new information)*
- **National Provider Identifier**
- **Revised Advance Beneficiary Notice** *(new information)*
- **Bidders Conferences for the Medicare DMEPOS Competitive Bidding Program**
- **Hospital Discharge Appeal Notices**

Physician Quality Reporting Initiative

Testing Opportunity for the Physician Quality Reporting Initiative

Eligible professionals interested in testing their billing system, and practice their readiness for PQRI quality data code reporting, will have a chance to do so. CMS has designated "G8300" as a test code for PQRI reporting prior to July 1, 2007, the start date for PQRI reporting. G8300 was formerly used in the 2006 PVRP program and will be retired on July 1, 2007; meaning it will be rejected on any claims submitted for dates of service on and after July 1, 2007. In the interim, it can be used to test readiness as follows:

1. Add the G8300 test code as a line item on any claims for services. On the ASC X12N health care claim transaction (version 4010A1), submit the HCPCS code G8300 in the SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

For claims submitted on the CMS 1500 Form, report the test code in field 24D.

2. Randomly enter "\$0.00 or "\$0.01" as the line item charge for the test code. This will confirm the ability of billing software or clearinghouses to accept either.

3. Check your Remittance Advice (RA) for these claims to assure the test code has been passed through and processed by the carrier or MAC. You should see Claim Adjustment Reason Code message 96, "Non-covered charge(s)." Also, you will see Remittance Advice Remark Code message N365, "This procedure code is not payable. It is for reporting/information purposes only." The RA will serve as your feedback for the test. CMS will not issue any other feedback.

4. The RA will indicate that the test code was denied. The test code will also show up on the beneficiary's MSN with the statement "This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount." This same message will be appear on MSNs during the 2007 PQRI reporting period for designated 2007 PQRI codes.

Though eligible professionals are free to test until July 1, CMS will be conducting some back end testing in June, so to the extent possible, we ask that eligible professionals submit some claims with the PQRI test codes as described above prior to May 30, 2007.

Important 2007 Physician Quality Reporting Initiative (PQRI) **Reminder**

National Provider Identifiers (NPIs) need to be included on the line level for the claims to be used in the PQRI analysis. Providers are encouraged to use this time to get into the habit of reporting line-level NPI information.

2007 Physician Quality Reporting Initiative (PQRI) National Provider Call Encore Replay

On May 24th, 2007 the Centers for Medicare & Medicaid Services hosted the third in a series of national provider calls on the 2007 Physician Quality Reporting Initiative.

For eligible professionals who were unable to attend, CMS is offering an Encore replay option of the call. This replay is accessible from 05/24/2007 until 05/31/2007, 11:59 p.m. EDT. The call-in data for the replay is (800) 642-1687 and the passcode is 8896727.

NPI: Get It. Share It. Use It.

The NPI Compliance Deadline is Here!

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. Please review the April 2, 2007 CMS “***Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule.***” As this guidance pertains to claims transactions, it means that:

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Advance Beneficiary Notice (ABN)

CMS Requests Additional Public Comment on the Revised Advance Beneficiary Notice (ABN)

A notice was published in the ***Federal Register*** on May 25, 2007 announcing the start of a second public comment period for the revised version of the ABN (CMS-R-131). The May 25 notice requests public comments on a revised ABN package that reflects changes made after the first round of public comments. Formerly, CMS maintained two versions of the ABN, a general and a laboratory specific. CMS is now proposing to combine these two versions of the ABN into a single notice meeting both needs. Other proposed changes are described in the website posting.

As required by Section 1879 of the Social Security Act, the ABN is used to inform beneficiaries of potential financial liability, except for certain institutional benefits such as home health and inpatient hospital. Physicians, practitioners, providers and suppliers already required to use ABNs, should continue using the currently approved ABNs until the revised notice is 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, choose "Advanced Search", then under "Search by Issue Date", choose search on the "Specific Date" and enter "05/25/2007" in the date field. Under "Search:" enter "CMS-R-131" (include the quotation marks).

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 your search again later 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

Comments must be received by 5 p.m. on Sunday, June 24, 2007.

Bidders Conferences for the Medicare DMEPOS Competitive Bidding Program

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We will also be posting a Power Point for participants to use during the Special Open Door Forum on Tuesday May 29, 2007.

I hope you all enjoy a wonderful Memorial Day Holiday Weekend!

Best regards ~ Valerie

*Valerie A. Hart, Director
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Planning & Development
Provider Communications Group, CMS*

7500 Security Boulevard
Mailstop C4-11-27
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FAX: (410) 786-0330

CMS Announces Financial Measures for the Medicare DMEPOS Competitive Bidding Program

Financial Measures for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) released today the measures that will be used to evaluate the financial stability of suppliers that bid under the new Medicare DMEPOS Competitive Bidding Program. All bids must include certain financial documentation in order for the supplier to be considered for a contract under the program. CMS and its Competitive Bidding Implementation Contractor (CBIC) will evaluate each bidder's financial documentation to determine whether the supplier will be able to participate in the program and maintain viability for the duration of the contract period.

The financial measures are standard accounting ratios commonly used to evaluate financial health. The following financial ratios will be used:

- Current ratio = current assets/current liabilities
- Collection period = (accounts receivable/sales) x 360
- Accounts payable to sales = accounts payable/net sales
- Quick ratio = (cash + accounts receivable)/current liabilities
- Current liabilities to net worth = current liabilities/net worth
- Return on sales = net sales/inventory
- Sales to Inventory
- Working capital = current assets – current liabilities
- Quality of earnings = cash flow from operations/(net income + depreciation)
- Operating cash flow to sales = cash flow from operations/(revenue – adjustment to revenue)

CMS and the CBIC will calculate each bidder's financial ratios using the financial information submitted as part of the bid. CMS and the CBIC will also be utilizing the supplier's credit history in evaluating the financial health of the supplier.

*Aryeh Langer for Valerie A. Hart, Director
Division of Provider Information
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Provider Communications Group, CMS
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Baltimore, MD 21244
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