

Provider Partnership Program (PPP) E-mail Notification Archives

July 2, 2007

Release of Medicare Physician Fee Schedule Proposed Rule

MEDICARE NEWS

FOR IMMEDIATE RELEASE

July 2, 2007

CMS PROPOSES POLICY, PAYMENT CHANGES FOR PHYSICIANS' SERVICES IN 2008

The Centers for Medicare & Medicaid Services (CMS) projects that it will pay approximately \$58.9 billion to 900,000 physicians and other health care professionals in calendar year (CY) 2008, under a proposed rule released today that would revise payment rates and policies under the Medicare Physician Fee Schedule (MPFS). This proposed rule is a further step in Medicare's efforts to ensure that payment policies provide incentives to improve the quality of care.

"This proposed rule builds on the changes the Centers for Medicare & Medicaid Services made last year to pay more appropriately for practice expenses and to transform Medicare into an active purchaser of higher quality services, rather than just paying for procedures" said acting CMS Administrator Leslie V. Norwalk, Esq. "It also includes an important new initiative to encourage the use of electronic prescribing to improve the speed and accuracy of care furnished to beneficiaries, as well as proposals for additional quality measures for use in the Physician Quality Reporting Initiative in 2008."

Comments will be accepted on the proposed rule until **August 31, 2007**, and a final rule will be published later in the fall. The final rule will be effective for services on or after January 1, 2008.

The proposed rule (CMS-1385-P) can be viewed on the CMS Website at <http://www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/CMS-1385-P.pdf>.

For your convenience, I have attached copies of both the CMS Press Release and Fact Sheet related to this proposed rule. The Press Release can also be obtained on the CMS Website at http://www.cms.hhs.gov/apps/media/press_releases.asp, and the Fact Sheet is posted at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.



PR11.MPFS08.NPRM FS05.E-Prescribe.06.
.07.02.07.pdf



29.07.pdf

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Your Monday Reading Materials

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

Hello everyone! Looks like the fireworks are starting early this week with several important news items already in the queue, including information on:

- Medicare Physician Fee Schedule Proposed Rule (also sent earlier today)
- New Outpatient Code Editor Resources
- Web Posting of American Medical Group Association (AMGA) Survey Data
- Participating CAP Physician Training
- HHS Demonstration to Fight DME Fraud

CMS PROPOSES POLICY, PAYMENT CHANGES FOR PHYSICIANS' SERVICES IN 2008

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New Outpatient Code Editor (OCE) Resources are Available on the CMS Website!

The Outpatient Code Editor (OCE) processes outpatient Medicare claims from/for all institutional providers. Understanding the OCE is important to institutional providers because the OCE performs three major functions:

- Edits the outpatient claim data to identify coding errors
- Assigns an [Ambulatory Payment Classification \(APC\)](#) number for each service covered under OPSS, and return information to be used as input to a Pricer program.
- Assigns an [Ambulatory Surgical Center \(ASC\)](#) payment group for services on claims from certain non-OPSS hospitals.

Effective for claims with dates of service July 1, 2007 and later, the non-Outpatient Prospective Payment System (non-OPSS) OCE will be integrated into the OPSS OCE. The resulting Integrated OCE will be used by Fiscal Intermediaries to process outpatient claims from both OPSS and Non-OPSS hospitals.

Claims from Non-OPSS hospitals with dates of service prior to July 1, 2007 will be routed through the last non-integrated update of the Non-OPSS OCE software (OCE v22.2) and will process with the versions in effect for the date of service on the claim.

Editing that was only applied to OPSS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to **non-OPSS hospitals** at this time. However, with the integrated OCE, non-OPSS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

In order to understand the OCE and to stay up-to-date with changes, providers are encouraged to:

- Visit the OCE webpage at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS web site and review the various sections;

- Review the OCE transmittal that is issued quarterly in order to identify any changes (OCE is updated generally at the beginning of January, April, July, and October); and
- Take the OCE web-based training course at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS Website. (A July 2007 version of this course is under development.)

American Medical Group Association Survey Data

In the May 11, 2007 *Federal Register* we stated that we would be posting on the web, the American Medical Group Association (AMGA) survey data to be used in determining the teaching physician portion of costs for “all or substantially all of the costs for the training program in the non-hospital setting.” Since publication of the final rule, we have revised our web posting of the AMGA survey data to include the salary data for both dentists and podiatrists. The AMGA data can be found at http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp .

Participating CAP Physician Training

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 participating CAP 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:

- 7/10/07 at 11:00 am CT
- 8/8/07 at 2:00 pm CT
- 9/12/07 at 2:00 pm CT
- 10/18/07 at 12:00 pm CT

HHS Fights Durable Medical Equipment Fraud
*Demonstration Project Targets Fraudulent Business Practices
in South Florida and Southern California*

HHS Secretary Mike Leavitt today announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment,

prosthetics and orthotics supplies (DMEPOS). The initiative is focused on preventing deceptive companies from operating in South Florida and Southern California.

The new initiative will have immediate effect in two regions of the country where there is a high concentration of suppliers, South Florida and Southern California. Based on the results of the project, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare Fraud Strike Force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the Southern District of Florida with fraudulently billing Medicare for more than \$258 million. The strike force is made up of federal, state and local investigators.

For your convenience, I have attached copies of the HHS Press Release and Fact Sheet on this topic. These documents will also be posted on the HHS Website at <http://www.hhs.gov/news>.



PR11.MPFS08.NPRM.FS05.E-Prescribe.06.
.07.02.07.pdf



DME Rls 7-2-07
(2).pdf



DME Fact Sheet
7-2-07 (2).pdf

If I don't 'talk' to you before then, I hope everyone enjoys a truly wonderful Fourth of July!!

With best regards ~ Valerie

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July 3, 2007

Reporting on the 2007 PQRI Begins!

Reporting on the 2007 Physician Quality Reporting Initiative (PQRI) Begins!

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 PQRI on claims for dates of service as of July 1, 2007, has begun. Eligible professionals can now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor.

Remember, all your informational needs can be met by visiting the PQRI website at, <http://www.cms.hhs.gov/PQRI>. Here you will find educational resources, including the PQRI Tool Kit, and links to our most Frequently Asked Questions (FAQs).

CMS also announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule. Included in the proposed rule is important information directly related to 2008 PQRI. To view or download the proposed rule, visit, <http://www.cms.hhs.gov/center/physician.asp>, click on CMS-1385-P, then go to page 402 of the document.

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July 5, 2007

Your Latest NPI Update!

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

New *MLN Matters* Article Available!

A new Special Edition *MLN Matters* article is now posted on the CMS website with important information for Medicare providers and suppliers. Some of the topics include:

- Common Enumeration Errors in NPPEs
- Dos and Don'ts When Reporting "Other Provider Identification Numbers" in NPPEs
- How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC
- How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs
- Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only

You can view this article by visiting
<http://www.cms.hhs.gov/MLNMMattersArticles/downloads/SE0725.pdf>
on the CMS website.

June 14, 2007 NPI Data Dissemination Roundtable Transcript Available Now

The transcript for the 6/14/2007 NPI Data Dissemination Roundtable can be found at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/6-14NPITranscript.pdf> on the CMS website.

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

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

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July 6, 2007

CMS Release of Modifications to the HCPCS Code Set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. This release includes 2 new modifiers required on claims billing Erythropoiesis Stimulating Agents (ESA) for in-center dialysis patients, in addition to 3 new modifiers required on claims billing ESAs for all non-ESRD related indications. These are necessary to implement the revisions to the ESA Monitoring Policy and the anemia reporting requirements of the 2006 Tax Relief and Health Care Act (TRHCA) respectively.

These changes have been posted to the CMS website at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp (View the first download under "Other-Codes.") The 5 new modifiers are effective on January 1, 2008. There are no new changes in this update effective October 1, 2007.

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ALERT – SPECIAL BIDDERS CONFERENCE FOR DMEPOS COMPETITIVE BIDDING PROGRAM!

ALERT – SPECIAL BIDDERS CONFERENCE FOR DMEPOS COMPETITIVE BIDDING PROGRAM

The Centers for Medicare & Medicaid Services (CMS) is holding a special 30 minute bidders conference call at 2:00 p.m. prevailing Eastern Time on July 9, 2007, to address issues associated with the bidding process for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Participant Call-in Number: (877) 356-8073, passcode 6553095

CMS is announcing a special bidders conference to discuss issues associated with the DME competitive bidding process. In the meantime, bidders should be aware that the Competitive Bidding Submission System (CBSS) automatically logs users out of the system after 2 hours due to a systems security setting built into the bidding process. At the special conference call CMS will discuss measures to expedite the overall bidding process and to manage data entered into the system.

Please be advised that suppliers should track their time while in the CBSS system. At the time at which a supplier is in the system for approximately 1 hour and 45 minutes, the supplier should save their data and log off the system entirely. After completely exiting the system, the supplier can go back and begin another session on the application.

In addition, suppliers should ensure that they keep their bidding session active by sending information to the server at least every 30 minutes. Suppliers should press the “update” or “submit” button on their current page or they should visit their home page by clicking on the “home” link on the top left corner of the application.

For more information on the program, please visit <http://www.dmecompetitivebid.com>

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July 9, 2007

PQRI Updates

Physician Quality Reporting Initiative (PQRI) Letter to Medicare Beneficiaries

The Centers for Medicare & Medicaid Services has posted a letter to Medicare beneficiaries with important information about the Physician Quality Reporting Initiative (PQRI) at, www.cms.hhs.gov/PQRI on the CMS website. The letter is

from Medicare to the patient explaining what the program is, and the implications for the patient. Physicians may choose to provide a copy to their patients in support of their PQRI participation.

To access the letter, visit, <http://www.cms.hhs.gov/PQRI>, on the CMS website. Once on the *Overview page*, scroll down to the “**Downloads**” section.

PQRI Questions of the Week

Q: If a Physician Quality Reporting Initiative (PQRI) quality-data code is not listed on a line adjacent to the correct Current Procedural Terminology (CPT) Category I code, will the quality-data code be accepted?

A: Yes, the PQRI analyses will match PQRI quality-data codes to the Current Procedural Terminology (CPT) Category I codes that appear on any non-denied service line on the claim, regardless of the order in which the various line items appear.

Q: If I report a modifier to a Physician Quality Reporting Initiative (PQRI) quality-data code on a claim, when use of that modifier is not specifically allowed per the PQRI Measure Specifications document, will I get credit for reporting?

A: No. In order to be considered an instance of appropriate quality data submission, PQRI quality-data codes should be accurate and reflect valid modifiers as in the measure specifications. Invalid codes will not be included in reporting or performance rate calculations.

Q: I have questions about which PQRI measures are most applicable to my specialty and practice, and how best to implement PQRI in my practice. Where can I get more information and advice on these topics?

A: For specialty- or practice-specific questions, please contact your professional organization or specialty association for guidance. In many cases, these organizations have information and tools to enable successful reporting of PQRI measures available on their websites.

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

A: The bonus cap calculation is defined as follows: (the individual's instances of reporting quality data) multiplied by (300%) multiplied by (the national average

per measure payment). The third factor, the "national average per measure payment amount" can only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by (the total number of instances where data were reported by all participants in the program for all measures during the reporting period.)

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

Example:

Dr. Smith had \$400,000 in allowed charges during the PQRI reporting period.

The 1.5% potential bonus is \$6000.

Dr. Smith reported quality data codes in 500 instances.

The national average per measure payment amount for 2007 was calculated in CY 2008 and turned out to be \$100 (\$100 M total national allowed charges claims submitted from July through December, divided by, 1 million instances of PQRI quality data codes being reported in the same time period).

The cap for Dr. Smith is \$150,000 (500 x 3 x \$100).

The bonus paid to Dr. Smith in early CY 2008 is \$6,000.

For a complete listing of all questions and answers about the 2007 PQRI, visit our website at, <http://www.cms.hhs.gov/PQRI>, and click on "All PQRI FAQs" available on any page.

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July 13, 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! Lots of information to impart this week, including news regarding:

- Medicare Clinical Laboratory Services Competitive Bidding Demonstration
- Special ODF on the Post Acute Care Payment Reform Demonstration (PAC-PRD)
- Updates to the Medicare Physician Fee Schedule Proposed Rule
- NPI Updates
- Revised Medicare Remit Easy Print Software
- Improvements Under the Medicare Physician Pay for Performance Demonstration
- Release of Final Regulation on Medicaid Prescription Drugs
- New from the Medicare Learning Network 

Medicare Clinical Laboratory Services Competitive Bidding Demonstration

UPDATE: The “Tentative Demonstration Test List” is now available under the Downloads section of the Medicare Clinical Laboratory Services Competitive Bidding Demonstration web page at <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10>.

REMINDER: The Centers for Medicare & Medicaid Services (CMS) will be hosting a Special Open Door Forum (ODF) to discuss the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project. The demonstration is mandated by section 302(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. This Special ODF is scheduled for **Monday, July 16, 2007 from 2:30pm-4:30pm Eastern Daylight Time**. The purpose of the demonstration is to determine whether competitive bidding can be used to provide quality laboratory services at prices below current Medicare payment rates.

Only laboratories meeting the requirements under the Clinical Laboratory Improvement Amendments (CLIA) program are eligible to participate in the demonstration by statute. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the demonstration or competitive bid area (CBA). The demonstration will set competitively bid fees in the CBA for

tests paid under the Medicare (fee for service) Part B Clinical Laboratory Fee Schedule, with the exception of Pap smears, colorectal cancer screening tests (which are excluded from this demonstration by statute), and new tests added to the Medicare Part B Clinical Laboratory Fee Schedule during the course of the demonstration.

We have planned this Open Door Forum to share the DRAFT Bidder's Package (posted on the project webpage at <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10>) and a tentative timeline for the project.

The DRAFT Bidder's Package includes information about the bidding process and other operational policies. CMS will then moderate an open discussion where ODF participants will have an opportunity to interact with CMS and our research contractor, Research Triangle Institute, International (RTI) in an informal dialog about the DRAFT Bidder's Package.

We look forward to your participation.

Open Door Forum Participation Instructions:

There are 2 ways to participate, by phone or in person.

1. To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID 2359678

(Persons participating by phone **do not** need to RSVP.)

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.

2. To participate in person:

Your RSVP is required. Please send a reply to CMS HOSPITALODF-L@cms.hhs.gov by **2:00 PM EDT, July 13, 2007**. Be sure to include the title of the forum "**Special Medicare Clinical Lab**" in the subject line of your message, and send us your name, organization/representation and telephone number.

Upon entry into the campus and building, you will be required to show Government issued photo identification, preferably a valid driver's license, and are subject to baggage or vehicular search before entering the complex.

Please arrive no later than 1:30 PM.

ADDRESS:

Single Site Building

CMS Auditorium

7500 Security Boulevard

Baltimore, Maryland 21244

Map & Directions: <http://cmsnet.cms.hhs.gov/hpages/ocsq/cmsdirections-north.htm>

ENCORE: 1-800-642-1687; **Conf. ID# 2359678**

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID. This recording will be accessible beginning 2 hours after the conference has ended. The recording expires after for 4 business days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list registration) and to view Frequently Asked Questions please visit our website at:

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

**Special Open Door Forum on the
Post Acute Care Payment Reform Demonstration (PAC-PRD)
Thursday, July 26, 2007, 2:30pm to 4:30pm**

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on plans for implementing data collection for the Post Acute Care Payment Reform Demonstration (PAC-PRD)

As a component of the Deficit Reduction Act of 2005 (S1932.Title V. Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). PAC-PRD will collect data in acute care hospitals and four types of PAC providers: Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

Under PAC-PRD, a uniform patient assessment instrument is being developed. In the course of the demonstration, this patient assessment tool will be collected along with information on costs and resource use in the PAC settings. This data will subsequently be examined and analyzed. The primary analysis of the demonstration shall be to predict cost and resource use based on patient assessment information to develop PAC payment reform options. The results of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) may influence how Medicare pays for care across PAC settings and how patient assessments occur at hospital discharge and through subsequent PAC settings.

This ODF will focus on issues of how data will be collected and how facilities may become involved in this project and contribute to this ground breaking research.

We look forward to your participation.

Open Door Forum Participation Instructions:

There are 2 ways to participate, by phone or in person.

1. To participate by phone:

Dial: **1-800-837-1935** & Reference Conference ID: **9438143**.

Persons participating by phone **do not** need to RSVP. However, phone line capacity is limited so dial in early.

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 assist you.

2. To participate in person:

This meeting will be located on Federal property, so for security reason any person wishing to participate in person is required to register: send an email to **SPECIALODF@cms.hhs.gov by 8:00 AM EST, Tuesday July 24, 2007.**

Include the words **“Special ODF: PAC-PRD - in person”** in the subject line of your message, and send us your name, organization or representation and phone number.

Please arrive no later than 2:00 PM EST. Upon entering the CMS building you will be required to show government-issued identification to Security officers and you may be subject to baggage search.

ADDRESS:

Single Site Building

CMS Auditorium

7500 Security Boulevard

Baltimore, Maryland 21244

Map & Directions: <http://cmsnet.cms.hhs.gov/hpages/ocsq/cmsdirections-north.htm>

To listen to an audio recording of the ODF:

An audio recording of this call that can be accessed through the "Encore" system by dialing:

1-800-642-1687 and entering the Conference ID # **9438143.**

A recording will be available beginning 2 hours after the conference has ended and it will expire after 4 business days.

If you have questions or require special accommodations, please contact Shannon Flood at Shannon.Flood@cms.hhs.gov or (410) 786-2583.

Updates to the Medicare Physician Fee Schedule Proposed Rule

Proposed Rule: CMS-1385-P - Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

The document currently on public display at the Office of the Federal Register has been updated to reflect the following changes:

- On page 3, lines 4 through 6, the "DATES" section reflects two different comment period closing dates.
- On page 7, line 5, the contact person's name and phone number for

issues related to physician self-referral rules.

- On page 340, line 13, after the phrase "the False Claims Act;" an additional criterion (criterion number 5) as follows: "(5) the parties have brought (or will bring as soon as possible) the arrangement into complete compliance with the prescribed criteria of the exception or have terminated (or will terminate as soon as possible) the financial relationship between or among them;"

These changes are also reflected in the file posted on the CMS website at:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDIID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1200867&intNumPerPage=10>

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

Reminder – July 16 is the Deadline by which Updates/Changes/Deletions Must Be Submitted to NPPES in Order to be Reflected in Initial Downloadable File

In order for providers' updates, changes, and deletions to be reflected in the initial downloadable file of NPPES data, providers must ensure that their updates, changes, and deletions are submitted to NPPES no later than July 16, 2007. To ensure the inclusion of updates, changes, and deletions in the initial downloadable file, July 16 is the last date on which they may be submitted via the web-based process, and is the last date by which the NPI Enumerator can receive them on the paper NPI Application/Update form (CMS-10114).[1]

The document is entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements – Data Dissemination – Information for Providers" and is available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf on the NPI website. We strongly recommend that providers read this document as soon as possible.

Updates, changes, and deletions that are submitted after July 16 will be reflected in the appropriate monthly update file, also downloadable from the Internet. For example, an update submitted on July 26 would be effective after the creation of the initial downloadable file and thus would be reflected in the first update file (to be created 1 month after the creation of the initial downloadable file); an update submitted on August 30 would be effective after the creation of the first update file and thus would be reflected in the second update file (to be created 1 month after the creation of the first monthly update file).

After the initial downloadable file is made available, an update file will be available each month thereafter at the same Internet location. All of the files (the initial file and the update files) will remain available for download at that Internet location.

The NPI Registry will operate in a real-time environment. Updates, changes, and deletions will be reflected in the NPI Registry at the same time they are reflected in NPPES. Therefore, the July 16 date is insignificant with respect to the data in the NPI Registry.

Still Confused?

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

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

Revised Version of the Medicare Remit Easy Print (MREP) Software Now Available

You can access the latest version of MREP at http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

What's New

National Provider Identifier (NPI) Changes

- Updates have been made to the MREP software to allow for the Stage 3 NPI changes that impact the 835v4010A1 transactions. The remittance advices that are generated (preview and print) from the Entire Remittance option and Claim Detail tab are being updated to accommodate the changes.
- The NPI value is being removed from the drop-down box on the Search tab. The Rendering Provider Number can be used to search for claim information whether the "rendering provider number" is a legacy number or an NPI value.

Enhancements

- Updates have been made to the Search Tab within the MREP software to allow a user to search claim information for a National Drug Code (NDC).
- The heading "Procedure Code" is being changed to "Product/Service ID" on the Search Tab and Search Result Listing print/preview to accommodate those claim lines that have a National Drug Code (NDC).
- The heading "Proc/Mod" is being changed to "Prod/Serv ID" on the various claim line level reports to accommodate those claim lines that have an National Drug Code (NDC). The reports that are affected are Adjusted Service Lines, Deductible Lines, Coinsurance Lines, Deductible/Coinsurance Lines, and Denied Service Lines.

Remember, you can save time and money by taking advantage of **FREE** MREP software available to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835!

Note: Since changes were made to the MREP software, the updated Claim Adjustment Reason Codes and Remittance Advice Remark Codes file is included with version 2.2 of the MREP software. However, the separate codes.ini file is provided when the MREP software is distributed.

PHYSICIAN GROUPS IMPROVE QUALITY AND GENERATE SAVINGS

**UNDER MEDICARE PHYSICIAN PAY FOR PERFORMANCE
DEMONSTRATION**

The Centers for Medicare & Medicaid Services announced that all participating physician groups improved the clinical management of diabetes patients in the first year of the three-year Medicare Physician Group Practice (PGP) Demonstration. This demonstration rewards providers for coordinating and managing the overall health care needs of Medicare patients with chronic conditions. To read the entire press release, please click here: http://www.cms.hhs.gov/apps/media/press_releases.asp

**Final Regulation: Medicaid Prescription Drugs- Average Manufacturer Price
(AMP)**

The Centers for Medicare & Medicaid Services recently placed on display at the *Federal Register*, the final regulation: Medicaid Prescription Drugs- Average Manufacturer Price (AMP). This regulation, required by the Deficit Reduction Act (DRA) of 2005, implements a new method of setting limits on what the federal government will reimburse state Medicaid agencies for prescription drug payments and is aimed at reigning in inflated drug product payments. This change is, in part, a reaction to reports issued in 2004 by both the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies were actually paying for those drugs.

Additional information can be found on the CMS website at the following links:

- AMP Press Release: http://www.cms.hhs.gov/apps/media/press_releases.asp
- AMP Fact Sheet: http://www.cms.hhs.gov/apps/media/fact_sheets.asp
- Medicaid Regulations Main Page:
http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp
- AMP Regulation (Direct Link to PDF File.):
<http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2238FC.pdf>
- Deficit Reduction Act (DRA) Main Page: <http://www.cms.hhs.gov/DeficitReductionAct/>

New from the Medicare Learning Network



Information to help you prepare for this year's flu season: *MLN Matters* Special Edition Article SE0727 – Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0727.pdf>

Provider Types Affected: Physicians, pharmacists, health care professionals, suppliers, and their staff.

I hope everyone enjoys a wonderful weekend!

With best regards ~ Valerie

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July 16, 2007

Materials for Today's ODF on Medicare Clinical Lab Services Competitive Bidding Demonstration Project

CMS is having technical difficulties posting slides for the 7-16-2007 ODF on the project webpage at

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10>)

Please see the **attached (pdf)** to access those slides until we can post them on the project webpage.

SPECIAL OPEN DOOR FORUM: MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION PROJECT

**Monday, July 16, 2007
2:30pm-4:30pm Eastern Daylight Time**

The Centers for Medicare & Medicaid Services (CMS) will be hosting this Special Open Door Forum (ODF) to discuss the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project. The demonstration is mandated by section 302(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The purpose of the demonstration is to determine whether competitive bidding can be used to provide quality laboratory services at prices below current Medicare payment rates.

Only laboratories meeting the requirements under the Clinical Laboratory Improvement Amendments (CLIA) program are eligible to participate in the demonstration by statute. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the demonstration or competitive bid area (CBA). The demonstration will set competitively bid fees in the CBA for tests paid under the Medicare (fee for service) Part B Clinical Laboratory Fee Schedule, with the exception of Pap smears, colorectal cancer screening tests (which are excluded from this demonstration by statute), and new tests added to the Medicare Part B Clinical Laboratory Fee Schedule during the course of the demonstration.

We have planned this Open Door Forum to share the DRAFT Bidder's Package (posted on the project webpage at <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10>) and a tentative timeline for the project.

The DRAFT Bidder's Package includes information about the bidding process and other operational policies. CMS will then moderate an open discussion where ODF participants will have an opportunity to interact with CMS and our research contractor, Research Triangle Institute, International (RTI) in an informal dialog about the DRAFT Bidder's Package.

We look forward to your participation.



handouts --
7-16-2007 ODF.PDF

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July 17, 2007

Payments for ASCs and Hospital Outpatient Departments

CMS REVISES PAYMENT STRUCTURE FOR AMBULATORY SURGICAL CENTERS AND PROPOSES POLICY AND PAYMENT CHANGES FOR HOSPITAL OUTPATIENT NEW STEPS TO ENCOURAGE HOSPITAL EFFICIENCIES AND QUALITY

The Centers for Medicare & Medicaid Services (CMS) issued a final rule revising the payment system for services furnished to people with Medicare in ambulatory surgical centers (ASCs) to better align payments for similar services furnished in a hospital outpatient department (HOPD) or a physician's office. CMS also issued a proposed rule that would update Medicare payment for services in HOPDs under the Outpatient Prospective Payment System (OPPS) and would set new payment rates for ASCs under the revised system effective for services in calendar year (CY) 2008.

The ASC final rule expands beneficiary access to surgical procedures in ASCs and implements steps to make ASC payments more accurate, while aligning payments across Medicare's payment systems to encourage efficient and appropriate choices of outpatient settings for ambulatory surgical procedures. CMS expects to make payments of almost \$3 billion in CY 2008 to the approximately 4,600 ASCs that participate in Medicare.

"The system we are announcing today will promote the goals of quality and efficiency in care furnished to people with Medicare in ambulatory surgical centers," said CMS Acting Administrator, Leslie V. Norwalk, Esq. "In addition, this revised system will take a major step toward eliminating financial incentives for choosing one care setting over another, thus assuring that patients' needs come first."

The proposed OPPS/ASC rule, published concurrently with the ASC final rule, would implement new steps to encourage more efficient care in hospital outpatient departments by providing hospitals with greater flexibility to manage their resources. The proposal also would ensure appropriate payment for high quality hospital outpatient services under the hospital Outpatient Prospective Payment System (OPPS). The reforms included in this proposed rule are intended to encourage quality and constrain rapid and accelerating growth in Medicare volume and expenditures for hospital outpatient services.

"As the number of services provided in hospital outpatient setting continues to increase annually," said Ms. Norwalk, "we are committed to working with hospitals to ensure the care provided to beneficiaries is appropriate, cost-effective and high quality. Today's proposed rule includes proposed hospital quality measures specific to hospital outpatient care, following the quality measures that have been successfully implemented in the hospital inpatient setting. In addition, this rule's proposal to increase the size of the OPPS payment bundles will give hospitals the flexibility to manage their resources in the most efficient way possible."

Revised Payment Methodology For ASCs

The final rule allows ASCs to be paid for any surgical procedure that CMS determines does not pose a significant safety risk to Medicare beneficiaries when performed in an ASC and that is not expected to require an overnight stay. As a result, the final rule adds about 790 procedures for ASC payment beginning in CY 2008. The proposed OPPS/ASC rule would add several additional procedures, which would result in approximately 3,300 covered surgical procedures under the revised ASC payment system. CMS expects that as a result of the significant expansion of surgical procedures paid in ASCs, beneficiaries will experience greater access to surgical services in appropriate settings.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to revise the ASC payment system no later than January 1, 2008. Consistent with the recommendations of the November 2006 Government Accountability Office Report (GAO Report) on ASC costs and payment, CMS is implementing the revised ASC payment system using hospital OPPS relative payment weights as a guide.

The revised ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. As required by the MMA, the revised ASC payment system is budget neutral; that is, it is estimated to have no net effect on Medicare expenditures in CY 2008 compared to the level of expenditures that would have occurred in the absence of the revised payment system. Consistent with the GAO Report, which found that procedures performed in ASCs are generally less costly than those performed in the HOPD, the proposed ASC payment rates for CY 2008 are estimated to be set at 65 percent of the OPPS rates for the corresponding procedures.

Many of the surgical procedures that are included as covered surgical procedures eligible for payment in ASCs under the revised system are procedures that have been performed predominantly in physicians' offices. To avoid creating payment incentives to perform those services in ASCs when they could be safely performed at less cost to Medicare and the beneficiary in a physician's office, payment for surgical procedures identified as 'office-based' is capped at the nonfacility practice expense component of Medicare's Physician Fee Schedule (MPFS) payment rate in the physician office setting. A separate payment to the physician performing these surgical procedures would be made for their professional services provided in the ASC facility.

Under the revised system, Medicare will make separate payment for covered ancillary services, such as radiology services and some drugs and biologicals that are provided integral to covered surgical procedures. Medicare will also provide separate payment to ASCs for the brachytherapy sources that are implanted through surgically placed needles in the treatment of prostate cancer. In addition, Medicare will make payment adjustments for those ASC procedures with high device costs which ensure that the ASC payment includes the same payment for an implantable device as when the procedure is performed in a hospital outpatient department. Procedures with high device costs are those in the OPPS for which the cost of the device equals or exceeds 50 percent of the median cost of the APC.

The ASC payment system will be updated annually through proposed and final rulemaking in close association with updates to the OPPS and the MPFS. The ASC payment rates in the CY 2008 OPPS/ASC proposed rule are based upon the policies of final ASC rule, updated to comport with the proposed OPPS APC recalibration and proposed OPPS payment policies for CY 2008.

The final CY 2008 ASC payment rates will be published in the OPPS/ASC final rule in November 2007, some of which will be incrementally phased in over a four year transition period, with their full implementation in CY 2011. In addition, CMS will account for geographic wage variation in individual ASC payments by applying the wage index to 50 percent of the ASC payment.

Proposed 2008 Policy And Payment Changes For HOPDs And ASCs

Prior to the implementation of the OPPS, beneficiary coinsurance for hospital outpatient services often resulted in beneficiary responsibility for more than half of the actual payment for the HOPD services. In the CY 2008 proposed rule, beneficiary liability under the OPPS would continue to be reduced under a formula that is designed to provide a gradual transition to 20 percent coinsurance. Based on the proposed rule, the aggregate beneficiary liability is estimated to be 26 percent of the total payment, and almost 3100 services (or 23 percent of all types of services billed under the OPPS) would meet the target coinsurance of 20 percent, increased from about 2600 (or 19 percent of all types of services) in CY 2007.

The proposed rule includes a 3.3 percent inflation update in Medicare payment rates for services paid under the OPSS for CY 2008. CMS projects that hospitals would receive \$34.9 billion in CY 2008 for outpatient services furnished to Medicare beneficiaries under the proposed rule. The proposed changes would affect outpatient services furnished by general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals.

These statutory payment increases are projected to continue a trend of rapid growth in hospital outpatient expenditures. CMS projects that the expenditures under the OPSS in CY 2008 will be approximately 10.5 percent higher than the estimated CY 2007 expenditures. The current rate of growth in expenditures is of great concern to CMS because of its impact not only on taxpayers, but also on beneficiaries whose monthly premiums must pay for 25 percent of Part B expenditures.

While payments to hospitals under the OPSS have increased over the years, these payment increases have not been specifically tied to quality improvements. The statute now requires that the annual payment update factor in CY 2009 and subsequent years be reduced by 2.0 percentage points for hospitals that do not report quality measures. This proposed rule proposes 10 hospital outpatient quality measures for purposes of the quality reporting requirement.

The proposed quality measures include five emergency department acute myocardial infarction transfer measures, two surgical care improvement measures, and one measure each for the treatment of heart failure, community-acquired pneumonia, and diabetes. CMS is also seeking public comment on 30 additional measures that are under consideration for reporting in future years.

CMS is also proposing to increase the size of the OPSS payment bundles as recommended by the Medicare Payment Advisory Commission (MedPAC). This proposal would provide greater flexibility to hospitals in implementing efficient care. Currently, certain items and services, including low cost drugs, anesthesia services, operating and recovery room use, implantable devices, and medical supplies are packaged in the payment for the associated APCs. CMS is proposing to package payment for seven additional categories of supportive and ancillary services in order to encourage hospital efficiencies in selecting the most clinically appropriate diagnostic and treatment approaches.

In addition, CMS is proposing to establish a new type of APC, called a composite APC, through which a single payment would be made for multiple major procedures performed in a single hospital encounter. CMS is proposing to establish two composite APCs for 2008, one for low dose rate prostate brachytherapy and one for cardiac electrophysiological evaluation and ablation. These composite APCs allow CMS to use the most complete data for rate setting when procedures are commonly provided in combination with one another.

In conjunction with the quality measures and the expanded bundle proposals, CMS is also soliciting public comments on other effective approaches to value-based purchasing that would promote high quality care and encourage hospital efficiencies in light of the continued growth in hospital outpatient expenditures.

CMS is proposing to pay separately for drugs, biologicals, and therapeutic radiopharmaceuticals costing more than \$60 or more per day in CY 2008, consistent with the historical \$50 threshold but updated for inflation. Payments for other drugs would continue to be bundled into payments for their associated procedures. However, as in past years, CMS is proposing to make an exception to the bundling policy for certain anti-nausea drugs often used by cancer patients to counteract side effects of treatment.

Comments on the proposed rule will be accepted until September 14, and a final OPSS/ASC payment rule will be published later this fall.

For the text of the ASC final revised payment system rule and supporting documentation, go to CMS-1517-F at http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp. For ASC

information in the proposed rule (CMS-1392-P), go to CMS-1392-P at [http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P\(ASC\).asp](http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P(ASC).asp) .

For the OPPS proposed rule (CMS-1392-P) and supporting documentation, go to:

<http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1201238&intNumPerPage=10>

For Fact Sheets on the final ASC rule and the combined OPPS/ASC proposed rule, go to:

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

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HHS Fights Home Health Agency Fraud

HHS Fights Home Health Agency Fraud

*Demonstration Project Targets Fraudulent Business Practices
in the Greater Los Angeles and Houston Areas*

HHS Secretary Michael Leavitt today announced an initiative designed to protect Medicare beneficiaries from fraudulent Home Health Agency (HHA) providers. This two-year project will focus on preventing deceptive providers from operating in the greater Los Angeles and Houston areas.

“HHS is working to protect the public from fraud by stopping it before it happens,” Secretary Leavitt said. “Our joint effort with the Department of Justice shows that we have zero tolerance for those who would prey on the system. This demonstration project works to bar unlawful Home Health Agencies from entering the Medicare billing system.”

In May, HHS and the Department of Justice announced the establishment of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. The HHA project follows the announcement of a demonstration project targeting another high-risk industry, fraudulent billing by suppliers of durable medical equipment,

prosthetics, orthotics and supplies (DMEPOS) in South Florida and Los Angeles. The HHA demonstration is being implemented in the greater Los Angeles and Houston areas, which have shown a high frequency of home health care fraud.

For your convenience, I have attached copies of the HHS Press Release and Fact Sheet on this topic. HHS has posted the Press release on their website here:

<http://www.hhs.gov/news/press/2007pres/07/pr20070717a.html>

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



HHA - 7-17-07.doc HHA FS 7-17-07.doc

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July 19, 2007

CMS extends the bid submission deadline for the first round of the Medicare DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission deadline for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Please note: All bids are now due by 9:00 p.m. prevailing Eastern Time on July 27, 2007.

- On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. *All bids are now due by 9:00 p.m. prevailing Eastern Time on July 27, 2007.*

- The registration deadline for USER IDs and passwords has closed. CMS is continuing to process complete and accurate requests for USER IDs and passwords for suppliers that applied for registration by the July 7, 2007 deadline. If you applied for registration by the July 7, 2007 deadline but have not yet received your USER ID and password and have not already contacted the Competitive Bidding Implementation Contractor (CBIC), please contact the CBIC via e-mail by 6 p.m. prevailing Eastern Time on July 20, 2007. The CBIC's e-mail address is: cbic.teleconference@palmettogba.com. The e-mail must contain the following information: supplier name; NSC number; contact name, e-mail address, and telephone number; authorized official name and telephone number; date of registration; and REQ number (this number can be found in the e-mail you received when you registered). Inquiries received after 6 p.m. prevailing Eastern Time on July 20, 2007 may not be able to be processed.
- Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. 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/>
- There are revised customer service hours at the CBIC. Effective immediately, the CBIC help desk will be available to assist you from 6 a.m. until midnight EST. The CBIC help desk will operate 24 hours a day the last day before bidding closes. You may call the help desk at 877-577-5331.

For more information on the program, please visit <http://www.dmecompetitivebid.com>

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July 20, 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 would like to take this opportunity to welcome our newest provider partner, the Visiting Nurse Associations of America, and thank them for graciously allowing CMS to videotape our meeting this past week. We intend to use that footage as the foundation for several products we are developing to help promote the Medicare Learning Network  and all of the wonderful FREE provider education resources it offers. I'll certainly keep everyone apprised of that development. In the meantime, I offer you information this week on the following topics:*

- **Open Door Forum Updates**
- **Clearinghouse Use of NPIs in Claim Submissions**
- **Medicare Part B Drug Competitive Acquisition Program (CAP) Updates**

Open Door Forum Updates

Medicare Clinical Laboratory Services Competitive Bidding Demonstration ~

As mentioned during **the July 16, 2007** Special Open Door Forum (ODF) on Medicare Clinical Laboratory Services Competitive Bidding Demo Project, the handouts used during the ODF have been posted on the CMS website. You may view them at:
<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10> and click on the Handouts 7/16/07 ODF link in the Downloads section.

#

Revised Payment System for Ambulatory Surgery Centers ~

SPECIAL OPEN DOOR FORUM:

Revised Payment System for Ambulatory Surgery Centers

Tuesday, July 31, 2007

2:00 PM – 3:30 PM EDT

Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on CMS-1517-F, “Revised Payment System for Services Furnished in Ambulatory Surgical Centers (ASC) Payment System and Calendar Year 2008 Payment Rates” and the ASC-related portion of CMS-1392-P, “Proposed Hospital Outpatient Prospective

Payment System and CY 2008 Payment Rates, Proposed Ambulatory Surgical Center Payment System and CY 2008 Payment Rates." The final rule adopts the payment policies for the revised ASC payment system to be implemented January 1, 2008. The proposed payment rates for ASCs for CY 2008 are included in the combined OPPS/ASC proposed rule since the ASC payment rates are based on the OPPS relative payment weights. The final CY 2008 ASC payment rates will be published in a combined CY 2008 OPPS/ASC final rule later this fall.

The revised ASC payment system will be implemented January 1, 2008.

We look forward to your participation.

To participate:

Dial: 1-800-837-1935 & Reference Conference ID: **6982411**

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.

Audio Replay:

An audio recording of this special forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning August 3, 2007.

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

As always, thank you for your continuing support of CMS Open Door Forums.

Clearinghouse Use of NPIs in Claim Submissions

It has come to the attention of Centers for Medicare & Medicaid Services (CMS) that some Clearinghouses are stripping the National Provider Identifier (NPI) prior to submission of the claim to Medicare. This will adversely affect Eligible Professionals in that these claims will not count toward PQRI participation. CMS urges Eligible Professionals that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the Eligible Professional determines that their clearinghouse is stripping NPIs from the claim, the Eligible Professional may want to consider other billing options.

A recent Special Edition MLN Matters article contains important information for Medicare providers and suppliers, including how to use the NPI correctly on Part A and

Part B claims. You can view this article by visiting <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website.

Medicare Part B Drug Competitive Acquisition Program (CAP) Updates

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 are expecting to begin participating in the CAP effective August 1, 2007 but have NOT received a welcome call from the approved CAP vendor, you are requested to 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 .

Or, you may contact the approved CAP vendor to determine whether they have received your information. The approved CAP vendor can be reached at (888)-899-7447.

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.**

I hope you enjoy a safe and relaxing weekend!

With warm regards ~ Valerie

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July 23, 2007

Special ODF on Post Acute Care Payment Reform Demonstration (PAC-PRD)

**Special Open Door Forum on the
Post Acute Care Payment Reform Demonstration (PAC-PRD)
Thursday, July 26, 2007, 2:30pm to 4:30pm**

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on plans for implementing data collection for the Post Acute Care Payment Reform Demonstration (PAC-PRD)

As a component of the Deficit Reduction Act of 2005 (S1932.Title V. Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). PAC-PRD will collect data in acute care hospitals and four types of PAC providers: Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

Under PAC-PRD, a uniform patient assessment instrument is being developed. In the course of the demonstration, this patient assessment tool will be collected along with information on costs and resource use in the PAC settings. This data will subsequently be examined and analyzed. The primary analysis of the demonstration shall be to predict cost and resource use based on patient assessment information to develop PAC payment reform options. The results of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) may influence how Medicare pays for care across PAC settings and how patient assessments occur at hospital discharge and through subsequent PAC settings.

This ODF will focus on issues of how data will be collected and how facilities may become involved in this project and contribute to this ground breaking research.

We look forward to your participation.

Open Door Forum Participation Instructions:

There are 2 ways to participate, by phone or in person.

1. To participate by phone:

Dial: **1-800-837-1935** & Reference Conference ID: **9438143**.

Persons participating by phone **do not** need to RSVP. However, phone line capacity is limited so dial in early.

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 assist you.

2. To participate in person:

This meeting will be located on Federal property, so for security reason any person wishing to participate in person is required to register: send an email to SPECIALODF@cms.hhs.gov by **8:00 AM EST, Tuesday July 24, 2007.**

Include the words “**Special ODF: PAC-PRD - in person**” in the subject line of your message, and send us your name, organization or representation and phone number.

Please arrive no later than 2:00 PM EST. Upon entering the CMS building you will be required to show government-issued identification to Security officers and you may be subject to baggage search.

ADDRESS:

Single Site Building

CMS Auditorium

7500 Security Boulevard

Baltimore, Maryland 21244

Map & Directions: <http://cmsnet.cms.hhs.gov/hpages/ocsq/cmsdirections-north.htm>

To listen to an audio recording of the ODF:

An audio recording of this call that can be accessed through the "Encore" system by dialing:

1-800-642-1687 and entering the Conference ID # **9438143.**

A recording will be available beginning 2 hours after the conference has ended and it will expire after 4 business days.

If you have questions or require special accommodations, please contact Shannon Flood at Shannon.Flood@cms.hhs.gov or (410) 786-2583.

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July 24, 2007

Your Latest NPI Update!

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

During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf.

National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on August 1, 2007

The NPI Registry, a query-only database, will be operational on August 1, 2007. The NPI Registry will operate in a real-time environment. This means that FOIA-disclosable data for newly enumerated providers, as well as updates and changes to enumerated providers' FOIA-disclosable data, will be available in the NPI Registry as that information is applied to NPPES. The NPI Registry will enable a user to query by, for example, NPI or provider name, and will return a list of all NPPES records that meet the query specifications. The user selects from that list the NPPES records he/she wants to see. The NPI Registry will then display the FOIA-disclosable data for those records. About a week later, CMS will make available a file for downloading that will contain the FOIA-disclosable NPPES data of enumerated health care providers. Technical expertise will be required to download that file and to import that data into a relational database or to otherwise manipulate the data. CMS will be furnishing more information about data dissemination, including a "Read Me" file, Header File, and Code Value document for the downloadable file, and will make that information available on the CMS NPI web page at http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

Two New Educational Products Posted

Fact Sheets:

- For Providers who are Organizations
http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Org_Privi_web_07-03-07.pdf
- For Providers who are Sole Proprietors
http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Sole_Prov_web.pdf

Group Practices that Conduct Any HIPAA Standard Transactions MUST Have an NPI!

A group practice that conducts any of the HIPAA standard transactions is a covered health care provider (a covered entity under HIPAA) and, as such, must obtain and use an NPI. The providers employed by the group practice, on the other hand, are only furnishing services at the group practice; they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and obtaining claim status electronically). Therefore, these employed providers are not covered health care providers and are not required by the NPI Final Rule to obtain NPIs. However, as a condition of employment, the group practice could require these providers to obtain NPIs so that the group practice can use them to identify the employed providers as the Rendering Providers in the claims that the group submits to health plans. If these physicians prescribe medications, the pharmacies may require their NPIs because the pharmacies may be required by health plans to include the NPIs of prescribers in their claims. Additionally, health plans may require enrolled physicians, or any other enrolled providers, to obtain NPIs in order to participate in those plans.

Important Information for Medicare Providers

Members of Group Practices Need NPIs for Medicare Purposes

Group practices that bill Medicare electronically are covered providers and are required by regulation to obtain and use NPIs to identify themselves as the Billing and Pay-to Providers in Medicare claims. Medicare requires that providers who are identified as Rendering Providers in Medicare claims be identified by NPIs, whether or not they are covered providers. Therefore, group practices that are enrolled in Medicare will want to ensure that their members (physicians or other practitioners) obtain NPIs in order to ensure payments to the group practices by Medicare.

Issues with New CMS 1500 Form Version 08-05

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05) to Medicare. This new version of the form was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC). The NUCC is chaired by the American Medical Association (AMA), in consultation with the CMS. The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers all claims be submitted to Medicare electronically, the Administrative Simplification Compliance Act (ASCA) provides for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare must be prepared to receive and process paper claims. However, Medicare is not required to accept and process multiple versions of the 1500 form.

CMS began accepting the revised Form CMS-1500 in January 1, 2007 with a planned cutoff of the old version Form CMS-1500 (12-90) on April 1, 2007. However, formatting issues which were identified with Form CMS-1500 (08-05) printed stock and images sold by the Government Printing Office (GPO) forced CMS to extend the cut off date of the 12-90 version. CMS closely monitored the situation through our contractors and concluded that the formatting issue was solely limited to the GPO and, as such, moved forward with the planned phase out of the Form CMS-1500 (12-90) version. Beginning July 2, 2007, CMS began returning the 12-90 version of the form. However, it recently came to our attention that the GPO is still not in a position to accept and fill orders for the revised form. CMS recognizes that the ability to purchase the revised form is a critical factor in a provider's ability to comply with the July cut-off.

Our research of the 1500 form has shown that the revised Form CMS-1500 (08-05) is widely available for purchase from print vendors. However, CMS is not able to recommend specific print vendors as this would be seen as creating a marketplace advantage. In order to assist providers in locating the Form CMS-1500 (08-05), CMS recommends:

- Use local print media directories to search for print vendors;
- Contact other providers to inquire on their source for the form;
- Search "CMS-1500 (08-05)" or "CMS-1500 08/05" via the internet and locate online print vendors. Ask for samples before ordering to ensure that the formatting is correct;
- Contact the NUCC (www.nucc.org) for assistance.

Even though the Form CMS-1500 (08-05) experienced formatting difficulties, those issues were quickly resolved. Medicare contractors are currently receiving and processing the new 1500 form without issue. Therefore, CMS will continue to adhere to the July 2, 2007 mandatory cutoff of the Form CMS-1500 (12-90) version.

Note that in using the new CMS-1500 version 08-05, if you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should begin using your NPI also. If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

Potential Issues Related to Clearinghouse Practices

It has come to CMS' attention that some Clearinghouses are stripping the National Provider Identifier (NPI) off the claim prior to its submission to Medicare. This could adversely affect Medicare providers in two ways. First, providers may be under the false impression that their claims are being successfully submitted to Medicare, through their clearinghouse, using an NPI. Second, without the NPI, these claims will not count toward PQRI participation for Eligible Professionals. Stripping of NPIs may also be occurring even though the NPI appears on remittance advice because some clearinghouses are adding the NPI to the remittance prior to sending to the provider. CMS urges Medicare providers that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the provider determines that their clearinghouse is stripping NPIs from the claim, the provider may wish to consider other billing options.

CMS has also become aware that some clearinghouses are not forwarding to providers NPI informational claim error messages being sent by Medicare carriers. Part B Carriers currently use logic to bypass validating the NPI/legacy provider pair. While claims are being paid today based on the legacy identifier, these messages are designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers. These informational messages are a critical measure of the extent to which a provider will experience rejected claims once the bypass logic is lifted. Providers who use clearinghouses should make sure they are in fact receiving NPI informational claim error messages so that issues can be addressed timely.

Reminder: Don't Miss This Important MLN Matters Article

A recent Special Edition MLN Matters article contains other important information for Medicare providers and suppliers, including how to use the NPI correctly on Part A and Part B claims. You may view this article by visiting

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website.

Reminder: CMS Will Host National Roundtable on August 2nd

CMS will host a national Roundtable specifically to address certain NPI implementation issues. This roundtable is entitled: Fee-for-Service Medicare Q&A Session: Common Billing Errors. The MLN Matters article referenced above should be read prior to the call. It will be held on August 2, 2007 from 2-3:30 PM EDT. Please visit

http://www.cms.hhs.gov/nationalprovidentstand/Downloads/NPI_FFS_MEDICARE_NPI_Q&A_SESSION.PDF for registration details.

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.

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

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July 25, 2007

Special ODF on the Post Acute Care Payment Reform Demonstration--Follow-Up Information

Special Open Door Forum on the
Post Acute Care Payment Reform Demonstration (PAC-PRD)
Thursday, July 26, 2007, 2:30pm to 4:30pm EST

An agenda for the ODF and background materials on the PAC-PRD can be found in the demonstrations portion of the CMS website. The web page is
<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1201325>

Please refer to the Special ODF website for participation information:
http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage .

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July 27, 2007

Latest Update to the DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission, registration, and accreditation deadlines for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Please note: All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007. Suppliers that have already submitted their bids may revise and resubmit their bids until the new deadline. Suppliers that resubmit bids must submit a new certification statement.

- On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. ***All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007.***
- Suppliers interested in bidding must first register and receive a User ID and Password before they can access the internet-based bid submission system. Registration opened on April 9, 2007. The original registration deadline was June 30, 2007. CMS has reopened registration. ***The registration deadline is now August 27, 2007.***
- Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding was originally August 31, 2007. ***The accreditation deadline is now October 31, 2007.***
- CMS is revising the contract periods. The original contract period for mail order diabetic supplies was April 1, 2008 – December 31, 2009. The contract period for all other first round product categories was April 1, 2008 – March 31, 2011. ***The contract period for mail order diabetic supplies is now July 1, 2008 – March 31, 2010. The contract period for all other first round product categories is now July 1, 2008 – June 30, 2011.***
- CMS is providing a targeted period to address suppliers' remaining questions on the competitive bidding program. To help ensure that answers are available as soon as possible, please e-mail your questions to the Competitive Bidding Implementation Contractor (CBIC) no later than August 10, 2007. The e-mail address is cbic.admin@palmettogba.com.
- There are revised customer service hours at the Competitive Bidding Implementation Contractor (CBIC). Effective immediately, the CBIC help desk will be available to assist you from 9 a.m. until 9 p.m. EST, Monday through Friday. You may call the help desk at 877-577-5331.

For more information on the program, please visit <http://www.dmecompetitivebid.com>

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Your Friday Reading Materials

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

Happy Friday everyone! I sincerely hope you are enjoying your summer and any vacation plans that you have made. This week's news items include information on the following topics:

- **Changes to the Methodology Used to Pay CAP Vendor Claims**
- **New Certification Rule for Organ Transplant Centers**
- **Medicare to Modify Its Claims Monitoring Policy For Use Of Erythropoiesis Stimulating Agents (Esas) For Anemia Treatment In Dialysis**
- **Medicare Releases Positive Results On Provider Satisfaction With Fee-For-Service Contractors**
- **Special ODF on the Proposed Clinical Research Policy National Coverage Determination (CRP NCD)**
- **New from the Medicare Learning Network**



Changes The Methodology Used To Pay CAP Vendor Claims

Section 108 of the Tax Relief and Healthcare Act of 2006 (TRCHA) changes the methodology used to pay CAP vendor claims as follows:

- Payment is now made for the approved CAP vendor's drug claim based upon receipt of a vendor's claim. Previously, payment was based upon the drug's administration claim.
- Section 108 also requires the establishment of a post-payment review process. This is done to assure that payment for a drug or biological is made only if the drug or biological has been administered to the beneficiary. Any overpayments identified by this process are required to be recouped, offset, or collected from the approved CAP drug vendor. To facilitate the post-payment review process, CMS

and the CAP designated carrier, Noridian, may request beneficiaries' medical records and other related documents from elected CAP physicians.

For additional information, please visit:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage and view TRHCA related documents in the Downloads section.

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:

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

New Certification Rule for Organ Transplant Centers

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.

***MEDICARE TO MODIFY ITS CLAIMS MONITORING POLICY FOR USE OF
ERYTHROPOIESIS STIMULATING AGENTS (ESAs) FOR ANEMIA
TREATMENT IN DIALYSIS***

The Centers for Medicare & Medicaid Services (CMS) announced it is strengthening its erythropoiesis stimulating agent (ESA) Monitoring Policy (EMP) for claims for ESAs used to treat anemia in Medicare beneficiaries who are receiving dialysis treatment for end stage renal disease (ESRD).

Since the last modification to this policy in October 2006, there have been several publications and a Food and Drug Administration “black box” warning that emphasize the risks facing ESRD patients who receive large doses of ESAs and have hemoglobin levels above 12 g/dL. Current Medicare coverage policy continues to provide that the hemoglobin be maintained between 10 and 12 g/dL. In response to the safety concerns, we are modifying the ESA monitoring policy to provide greater restrictions on the dosage amounts of ESAs for which payment is made for patients with levels that rise above 13 g/dL.

“CMS is committed to establishing and maintaining policies in all areas of Medicare that promote efficient and appropriate use of medical interventions, protect beneficiaries, and enable providers to furnish high quality care,” said Leslie V. Norwalk, CMS acting administrator.

Medicare’s current EMP requires a 25 percent reduction in the reported ESA dosage used by the dialysis facility for which payment will be made if the facility reports that the patient’s hemoglobin level exceeds 13 g/dl the facility includes a code, the GS modifier, on the claim. The GS modifier signifies that the facility has reduced the patient’s ESA dosage as a response to the hemoglobin/hematocrit level.

In the revised policy, CMS is adding a provision that will reduce by 50 percent the reported ESA dosage used by the dialysis facility for which payment will be made if the facility reports that the beneficiary’s hemoglobin has exceeded 13 g/dL for three consecutive months including the current billed month. CMS will reduce the reported dosage even if the GS modifier is included on the claim.

In addition, under the revised policy Medicare will not pay for dosages of epoetin alpha (Epogen) in excess of 400,000 IUs per month or darbepoetin alpha (Aranesp) in excess of 1200 mcg per month. Dosages at these levels are unlikely and are generally the result of typographical errors rather than accurate dosage reports. CMS has lowered these limits from 500,000 IU and 1500 mcg respectively, after reviewing data from the current EMP.

While we are issuing the above as a final policy, we are encouraging the public to comment on this modification. CMS will use these comments to decide whether the Agency should further revise the policy. The final ESA claims monitoring policy can reviewed at http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=11.

ESAs are man-made versions of erythropoietin, a hormone that is produced naturally in the kidney and stimulates the bone marrow to make more red blood cells. ESAs are used to treat anemia and reduce the need for blood transfusions in patients with ESRD and chronic kidney failure. Medicare covers the use of ESAs in the treatment of anemia in beneficiaries with ESRD to maintain a hematocrit level between 30.0 and 36.0 percent. This is consistent with the Food and Drug Administration (FDA) label instructions for erythropoietin.

“We feel strongly that these revisions will support the clinically sound and prudent management of anemia in dialysis patients,” said Barry Straube, MD, CMS’ Chief Medical Officer and a nephrologists. The revised policy will be effective for claims of service on and after Jan 1, 2008.

MEDICARE RELEASES POSITIVE RESULTS ON PROVIDER SATISFACTION WITH FEE-FOR-SERVICE CONTRACTORS

According to the Medicare Contractor Provider Satisfaction Survey (MCPSS), most Medicare health care providers continue to be satisfied with services provided by Medicare fee-for-service contractors. The MCPSS, conducted by the Centers for Medicare & Medicaid Services (CMS) for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. Sixty-five percent of those who were surveyed responded. The survey revealed that for the second consecutive year, 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale.

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

For more information on the Medicare Contractor Provider Satisfaction Survey (MCPSS), go to www.cms.hhs.gov/MCPSS on the CMS Website.

To read the CMS Press Release issued on 7/25/07, click here:
http://www.cms.hhs.gov/apps/media/press_releases.asp

**Special Open Door Forum on the
Proposed Clinical Research Policy National Coverage Determination
(CRP NCD)**

Tuesday, August 7, 2007

2:00pm to 4:00pm EDT

CMS Auditorium

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on the proposed Clinical Research Policy National Covered Determination (CRP NCD) issued on July 20, 2007.

The Agency requests public comments on this proposed determination pursuant to Section 731 of the Medicare Modernization Act. The comment period will close on August 19, 2007. We will issue the final decision 60 days after the end of the comment period, October 20, 2007.

The purpose of this Open Door Forum is to facilitate discussions among the public and between the stakeholders and the Agency on all of the matters addressed in this proposed CRP NCD. We believe that engaging the public in this way will increase our understanding of the issues of concern as well as provide potential solutions.

This proposed CRP NCD reflects significant changes to the CTP NCD issued on July 9, 2007. This proposed decision memorandum was informed by considerable contributions from the public. While it proposes to maintain the two modifications to the 2000 CTP, it puts forth definitions of clinical research, usual patient care, routine and investigational clinical services, and administrative services; recommends technical and scientific standards for research studies that Medicare supports; and suggests a process by which study sponsors/principal investigators may certify that a clinical research study meets the Medicare standards of a good study.

The public and the Agency have spent considerable time and effort in crafting this proposed CRP NCD. We strongly believe that it is in the best interest of all parties and the development of scientific knowledge to provide quality care to improve health outcomes, to have an opportunity beyond that of written comments to engage in discussions on this topic.

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: **10584169**

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.

ADDRESS:

Single Site Building
CMS Auditorium
7500 Security Boulevard
Baltimore, Maryland 21244

Map & Directions: <http://cmsnet.cms.hhs.gov/hpages/ocsq/cmsdirections-north.htm>

Audio Replay:

An audio recording of this special forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning **August 13, 2007**.



New from the Medicare Learning Network

The revised *Sole Community Hospital Fact Sheet* (March 2007), which provides information about Sole Community Hospital classification and payments, is now available in print format from the **Medicare Learning Network**. To place your order, visit www.cms.hhs.gov/mlngeninfo, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

I hope you have a great weekend ~ Valerie

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