

Provider Partnership Program (PPP) E-mail Notification Archives

November 1, 2007

Medicare Final Rule Announces 2008 Physician Fees and Reforms for Accurate Payments and Quality

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

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MEDICARE FINAL RULE ANNOUNCES 2008 PHYSICIAN FEES AND REFORMS FOR ACCURATE PAYMENTS AND QUALITY

The Centers for Medicare & Medicaid Services (CMS) today issued a final physician payment rule designed to improve accuracy of Medicare payments and give physicians and health care professionals additional financial incentives to provide higher quality and value in the delivery of care.

Under the new rule, Medicare estimates that it will pay approximately \$58.9 billion to about 900,000 physicians and other health care professionals. The revised payments, quality incentive rates and related policy changes, which will become effective January 1, 2008, are included in the Medicare Physician Fee Schedule (MPFS) final rule. The rule went on display today at the *Federal Register*.

The final rule, effective for services on or after January 1, 2008, will go on display today and will be published in the *Federal Register* on November 27, 2007. The rule can be found at <https://www.cms.hhs.gov/center/physician.asp>.

To view the entire CMS Press Release issued today, go to http://www.cms.hhs.gov/apps/media/press_releases.asp on the CMS website.

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November 2, 2007

Medicare Hospital Outpatient Services in 2008

**NEW STEPS TO ENCOURAGE EFFICIENCY AND QUALITY FOR
MEDICARE HOSPITAL OUTPATIENT SERVICES IN 2008**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on Thursday, November 1, 2007, updating the hospital Outpatient Prospective Payment System (OPPS), effective for services furnished during calendar year (CY) 2008, which encourages higher quality and accessible health care through new payment policies and the reporting of quality measures. The final rule with comment period also updates the payment rates for the revised ambulatory surgical center (ASC) payment system, beginning in CY 2008.

Ultimately, the provisions of this final rule with comment period are expected to improve quality, encourage hospital efficiency, and make health care more affordable and accessible for Medicare beneficiaries.

This final rule with comment period affects outpatient services furnished by general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term acute care hospitals.

The final rule with comment period can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?itemID=CMS1204971> . It will be published in the Federal Register on November 27, 2007.

To read more of the OPPS press release issued today click here:
http://www.cms.hhs.gov/apps/media/press_releases.asp

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Important NPI Updates

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

Requirement to Update Information in the National Plan and Provider Enumeration System (NPPES)

Health care providers who are covered entities under HIPAA are required by the National Provider Identifier (NPI) Final Rule to update their NPPES data. The Final Rule [at (162.410(a)(4))] states that covered health care providers must notify the NPPES of changes in their required NPPES data elements within 30 days of the changes. Failure to provide updated information may be considered an act of non-compliance with the NPI regulation, and a complaint may be filed against covered health care providers who do not comply with this provision, or any other provisions of the rule.

Most updates and changes can be made by health care providers over the web, using the User IDs and passwords they selected when they first applied for their NPIs. If they applied on paper, most health care providers can submit updates or changes over the web and can select User IDs and passwords at the time of the update. Certain changes or updates, however, must be made on paper (form CMS-10114), as they require the original signature of the health care provider or, for an organization health care provider, the signature of the Authorized Official. Such changes include:

- 1) Applications for NPIs, and all updates/changes, from individuals who do not have SSNs or who do not want to report their SSNs to NPPES;
- 2) All requests to deactivate NPIs;
- 3) All requests to reactivate NPIs;
- 4) All changes to incorrectly submitted SSNs;
- 5) All changes to incorrectly submitted dates of birth;
- 6) All changes to incorrectly submitted Employer Identifier Numbers (EINs);
- 7) All changes of EINs;
- 8) Password resetting changes due to changes to the Contact Person or Authorized Official.

When to Contact the NPI Enumerator for Assistance

Your health plans cannot assist you with NPI questions that should be directed to the NPI enumerator. However, the issues with which the NPI Enumerator can assist you are also limited to the following topics:

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing this type of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at

CustomerService@NPIenumerator.com .

The NPI application is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update your record. You can also refer to the 'Application Help' tab located on the NPPES website for additional assistance while you are online.

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

Please Note: The NPI Enumerator's operation is closed on federal holidays

Important Information for Medicare Providers

Medicare Announces a New “Key” NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare Administrative Contractors (MACs), and DME MACs Using an Electronic Claim Form (ASC X12 837P) or Paper Claim Form (CMS-1500)

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a National Provider Identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully crosswalking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Medicare Informational Warnings to Those Who Are Not Submitting NPIs On Claims

Since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called “Provider Identification Code Qualifier Invalid Value” messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Testing Claims With Only the NPI

If you already bill using the NPI/legacy pair in the primary fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI alone is mandated on all claims. If the results are positive, begin increasing the number of claims in the batch. If your claims reject, first go into the NPPES website located at <https://nppes.cms.hhs.gov/> and validate that your information is correct and that you reported your Medicare legacy identifier(s) in the Other Provider Identification Numbers section. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the NPPES information is correct and you reported your Medicare legacy identifier(s), call your contractor and ask that they validate what is in their system.

Need More Information?

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 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. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking “CMS Communications” in the left column of the www.cms.hhs.gov/NationalProvIdentStand website.

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

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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!

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Happy Friday everyone ~ lots going on this week, including important information regarding the National Provider Identifier (NPI). In addition, I'm including information on:

- Payments for Graduate Medical Education (GME) for Affiliated Teaching Hospitals in Certain Emergency Situations
- November is American Diabetes Month
- CR 5567 - "Reporting of Additional Data to Describe Services on Hospice Claims"
- Your Flu Shot Reminder

You should have also received announcements yesterday afternoon and this morning regarding the Medicare Physician Fee Schedule and Outpatient Prospective Payment Final Rules—please let me know if you did not receive those announcements and I'll resend them to you.

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

Medicare Announces a New “Key” NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare Administrative Contractors (MACs), and DME MACs using an Electronic Claim Form (ASC X12 837P) or Paper Claim Form (CMS-1500).

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

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Payments for Graduate Medical Education (GME) for Affiliated Teaching Hospitals in Certain Emergency Situations

On November 1, 2007, CMS placed on display in the Federal Register a new interim final rule with comment period (IFC) about payments for Graduate Medical Education (GME) for affiliated teaching hospitals in certain emergency situations. This IFC is part of the CY 2008 OPPS final rule. CMS issued this IFC in response to hospitals' urgent requests for emergency Medicare GME affiliation agreements to be effective beyond June 30, 2008. Accordingly, CMS is modifying the emergency provisions in the IFC included with the CY 2008 OPPS final rule. The IFC extends the effective period for emergency Medicare GME affiliations from three academic years to up to five academic years in general, with certain limitations for out-of-State emergency affiliations beyond the initial three academic years. CMS is also providing for extended timeframes to meet the regulatory requirement for submitting the written agreement that allows a hospital to count residents training in non-hospital sites, for a hospital with a valid emergency Medicare GME affiliation agreement. This IFC will be printed in the Federal Register on November 27, 2007, and the comment period ends on January 28, 2008. The IFC is posted on the CMS Direct GME and Indirect Medical Education (IME) web pages at

http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp and
http://www.cms.hhs.gov/AcuteInpatientPPS/07_ime.asp.

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November is American Diabetes Month ~ Diabetes continues to be a prevalent health concern in the United States. Approximately 20.8 million Americans, or 7.0% of the population, have diabetes. Of these, 10.3 million people are age 60 and over. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes.

Covered diabetes screening tests include the following:

- A fasting blood glucose test, **and**
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults), **or**
- A 2-hour post-glucose challenge test alone.

We Need Your Help!

CMS needs your help to ensure that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take advantage of the diabetes screening tests.

In addition to providing coverage for diabetes screenings, Medicare also provides coverage for a variety of preventive care and other services for people with diabetes, such as the initial preventive physical examination (must be received within the first six months of the beneficiary's initial Medicare Part B coverage period), cardiovascular screening blood tests, diabetes self-management training, medical nutrition therapy, diabetes supplies, glaucoma screening, and influenza and pneumococcal immunizations. These services can help beneficiaries manage the disease and lower the risk of complications. Talk with your Medicare patients about the preventive services that are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible. Working together, we can help people with diabetes take steps to reduce the occurrence of serious complications through early detection and treatment, controlling the levels of blood glucose, blood pressure, and blood lipids, life style modifications (diet and exercise), and by receiving other preventive care practices as appropriate.

For More Information

- For more information about Medicare's coverage of diabetes screening services, initial preventive physical examination, cardiovascular screening blood tests, diabetes self management training, medical nutrition therapy, diabetes supplies, influenza and pneumococcal immunizations, and glaucoma screening services, including coverage,

coding, billing, and reimbursement guidelines, please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products web page http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>
- For more information about American Diabetes Month, please visit <http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp>

Thank you for partnering with CMS during American Diabetes Month as we strive to make sure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening tests and other Medicare-covered preventive services for which they may be eligible.

***** **CR 5567 - "Reporting of Additional Data to Describe Services on Hospice Claims"**

CMS has issued a revision to Transmittal 1304 (Change Request 5567) which was entitled "Reporting of Additional Data to Describe Services on Hospice Claims." This revision changes the effective date of Transmittal 1304 for additional service data on the claims only. Reporting of additional service data on hospice claims is now OPTIONAL for hospices effective on January 1, 2008. This reporting now becomes MANDATORY on July 1, 2008.

Hospices should note that all Medicare systems changes described in Transmittal 1304 will be implemented January 7, 2008 as scheduled. This is to allow hospices to exercise their option to beginning reporting for January dates of service. The changes are necessary for the optional information to be received and processed correctly.

It is important to note that this also means that the Medicare system edit restricting the use of V-codes as the principal diagnosis on a hospice claim will still go into effect for January 1, 2008 dates of service. Hospices must ensure they cease reporting V-codes as a beneficiary's principal diagnosis for January 1, 2008 dates of service whether or not they exercise their option to report additional service data.

The revision is found in Transmittal 1304 which can be accessed at the CMS Transmittals website: <http://www.cms.hhs.gov/Transmittals/2007Trans/itemdetail.asp?itemID=CMS1204950> .

November Flu Shot Reminder!

"Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the

importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu.**

Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website."

I hope everyone has a great weekend!

With best regards ~ Valerie

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November 6, 2007

2007 Physician Quality Reporting Initiative (PQRI) Update

2007 Physician Quality Reporting Initiative (PQRI) Update

Important Information About the Use of the National Provider Identifier (NPI)

PQRI participants must use their NPIs correctly for their quality-data submissions to count toward successful reporting.

In recent NPI related communications, CMS indicated that since October 15, 2007, Medicare is sending informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Medicare informational warnings called "Provider Identification Code Qualifier Invalid Value" messages will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages, your claim did not include an NPI as required for PQRI reporting. If you are certain that your claim was submitted with an NPI, you may want to contact your clearinghouse or billing agent to ascertain the reason

behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

PQRI Participation and Coding Tips

The Centers for Medicare & Medicaid Services has developed a Tip Sheet to assist eligible professionals participating in PQRI with reporting accuracy. Successful participation in PQRI is dependent on accurate submission of information provided on Medicare claims. This new resource provides helpful tips on the PQRI reporting process and is available on the PQRI web page at:

<http://www.cms.hhs.gov/PQRI/Downloads/2007PQRITipSheet.pdf>.

Other PQRI Resources

New information is continually added to the most reliable source of information about PQRI, the CMS website: <http://www.cms.hhs.gov/PQRI>. Here you will find new and revised Frequently Asked Questions (FAQ), updates on issues related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in PQRI. Many of the FAQs have been recently updated, so be sure to check the website if you have any questions.

Two of the newest FAQs are:

8691 –

Question: Where do I place the Physician Quality Reporting Initiative (PQRI) quality-data codes on the CMS-1500 claim form?

Answer: The 2007 PQRI quality-data codes are HCPCS codes and reporting requirements for these codes follow current rules for reporting other HCPCS codes (*e.g.* CPT Category I codes). For additional information, see FAQ #8255.

8687 –

Question: Are Medicare patients who are covered under Railroad Retirement Benefits and Postal Worker benefits included in the Physician Quality Reporting Initiative (PQRI)?

Answer: Yes.

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

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

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

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

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

The physician election form can be found at the following webpage in the Downloads section.

Additional information for physicians can also be found at this site:

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

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

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

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

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November 7, 2007

Hospital-Acquired Conditions (HAC) and Present on Admission (POA)
Indicator

**HOSPITAL-ACQUIRED CONDITIONS (HAC) AND PRESENT ON ADMISSION
(POA) INDICATOR**

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the launch of the new Hospital-Acquired Conditions (HAC) and Present on Admission (POA) Indicator website to provide reliable and timely information for affected providers on this quality of care initiative.

Section 5001(c) of the DRA required CMS to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. CMS has implemented POA reporting for all diagnoses to identify hospital-acquired conditions. Payment and reporting requirements are further explained on the dedicated web page.

All information pertaining to HAC & POA can be found at:
<http://www.cms.hhs.gov/HospitalAcqCond/> on the web. This page offers information on regulations, reporting, coding, and affected hospitals. Stay tuned for more information and educational products to be available, free of charge, on the HAC & POA web site, in the upcoming months.

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November 8, 2007

Your Friday Reading Materials

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

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Happy Friday everyone ~ I hope you had a good week. Items in today's message include information on:

- 2008 PQRI Provisions Announced in the Medicare Physician Fee Schedule Final Rule
- Modifications to the Healthcare Common Procedure Coding System (HCPCS) Code Set
- New Information Available on HH PPS Billing & Coding Website
- Updates Regarding the Medicare Part B Drug Competitive Acquisition Program (CAP)
- The Latest Article from CMS' Own Dr. Bill Rogers
- New from the Medicare Learning Network 
- Change to E-mail Update/Listserv Service
- Flu Shot Reminder

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2008 PQRI Provisions Announced in the Medicare Physician Fee Schedule Final Rule

The 2008 Medicare Physician Fee Schedule (MPFS) Final Rule, effective for services on or after January 1, 2008, is on display in the *Federal Register* and will be published on November 27, 2007. The rule identifies 119 measures CMS has selected for eligible professionals to use to report quality-of-care information under the 2008 PQRI. The rule can be found at: <http://www.cms.hhs.gov/center/physicians.asp>. The Physician Quality Reporting Initiative (PQRI) provisions begin on page 653. A summary of these provisions is available at: <http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMPFSSummary.pdf>.

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Modifications to the Healthcare Common Procedure Coding System (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. These changes have been posted to the "Alpha-Numeric HCPCS" list at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp>. All changes are effective January 1, 2008, unless otherwise indicated in the effective date column.

New Information Available on HH PPS Billing & Coding Website

The Centers for Medicare & Medicaid Services has posted new information regarding HH PPS case-mix refinements on the “HH PPS Coding & Billing” web page. The new resources include:

- Questions and Answers regarding transition episodes -- This document describes special steps for Home Health Agencies (HHAs) to take in completing their Outcome and Assessment Information Set (OASIS) assessments at the transition to the refined HH PPS January 1, 2008. These steps will assure HHAs can create the proper payment group code for their claims.
- HH PPS Health Insurance Prospective Payment System (HIPPS) code weight tables -- These spreadsheets map each of the 1836 new HIPPS code for the refined HH PPS to its associated case-mix weight and supply payment amount.
- Presentation on HH PPS claims processing changes -- An outline describing the principle changes to HHA coding and billing that result from the refined HH PPS.

To access this information, go to the Downloads section of the following page:
http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp on the CMS website.

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

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will conclude on **November 15, 2007**.

CAP election forms with missing or erroneous physician practice information will not be processed by local carriers. To avoid delays in the processing of your 2008 CAP election application, please:

- Be certain to furnish all the information required on the election form
- Be certain that all information such as UPIN numbers, addresses, and physician names are entered correctly and match the information on file with your local carrier (the carrier that processes your Part B drug claims)
- Be certain that the form is signed and dated by an authorized official (as defined on the form)
- Mail the completed and signed form to your local carrier. Election forms must be postmarked no later than **November 15, 2007**.

Please visit the “Information for Physicians” page on the CMS CAP website for additional program information:

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

The Latest from Dr. Bill

William D. Rogers, M.D., FACEP, Medical Officer in the Office of the Administrator Director at CMS, shares his most recent thoughts in the attached article, “**Medicare Part D: What to look for in 2008.**”

New from the Medicare Learning Network



The *Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet* (July 2007 version), which provides information about payment for physician services in teaching settings and general documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at <http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf>.

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The Centers for Medicare & Medicaid Services (CMS) has updated the following web-based (WBT) training course: ***Medicare Preventive Services Series: Part 2 Women’s Health***. This WBT course provides information to help fee-for-services providers understand Medicare’s coverage and billing guidelines for mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit, http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Website.

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A New Brochure for Health Care Professionals from the Medicare Learning Network Entitled “*Diabetes-Related Services*”

November is American Diabetes Month ~ The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes, as well as other covered services for people with diabetes. CMS has published a new provider brochure entitled ***Diabetes-Related Services***. This tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. You may download, view and print this new brochure by visiting the Medicare Learning Network (MLN) at

<http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvc.pdf> on the CMS website. Print copies of the brochure may be ordered, free of charge, from the MLN Product Ordering Page by visiting http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

For More Information

- For more information about Medicare's coverage of preventive services and screenings for people with diabetes, including the diabetes screening services, diabetes self management training, medical nutrition therapy, diabetes supplies, initial preventive physical examination, cardiovascular screening blood tests, influenza and pneumococcal immunizations, and glaucoma screening services, please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products web page http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>
- National Diabetes Education Program (NDEP) <http://ndep.nih.gov/> ~ NDEP provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.
- For more information about American Diabetes Month, please visit <http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp>

Change to E-mail Update/Listserv Service

The Centers for Medicare & Medicaid Services (CMS) will be offering a new e-mail update (or listserv) service that delivers Medicare information to Fee-for-Service (FFS) providers, suppliers, and their staff's Inboxes. Visitors to the <http://www.cms.hhs.gov> website will be able to sign up to receive updates relevant to Medicare Fee-for-Service providers & suppliers and to receive information on related topics. This new service will allow you to choose between many audience types and subjects of information, such as the National Provider Identifier (NPI), the Physician Quality Reporting Initiative (PQRI), and Preventive Services.

With this new service, you will be able to receive:

- The specific Medicare FFS provider payment messages of your choice, OR;
- FFS related-topic messages for which you want to receive information. Note: You must check the topics page often to see what new topics are available, OR;
- A new option; both of the above! All messages sent to all FFS Medicare provider payment lists and FFS topics.

With the new e-mail update service, you will have more subjects from which to subscribe and options regarding the frequency of e-mail updates. Your e-mail address will only be used to

deliver the information you request and to give you access to your profile of subscriptions. You will want to update your profile to select the topics you want. Once available, you can change your profile at any time. This is a free service provided by CMS.

You do not have to take any action! CMS will migrate your e-mail address automatically to this new e-mail service to the most appropriate corresponding subject/audience type. During this transition, you will continue to receive messages. However, if you prefer to subscribe to the new e-mail update service on your own, you may unsubscribe from your current listserv(s) at <http://www.cms.hhs.gov/apps/maillinglists/> before *Monday, November 26, 2007*. The new e-mail service should be accessible from the same URL.

The messages you currently receive from CMSProviderResource@cms.hhs.gov will come from cmslists@subscriptions.cms.hhs.gov. In order to ensure that you receive your subscription emails and announcements from <http://www.cms.hhs.gov/>, please add cmslists@subscriptions.cms.hhs.gov to your contact list, adjust your spam settings, or follow the instructions from your email provider on how to prevent our emails from being marked "Spam" or "Junk Mail." Thank you for your patience as we transition to this new service.

Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu.**

Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website.



Part D for 2008 -
HKH.DOC

I hope you have a wonderful Veterans Day weekend!

With best regards ~ Valerie

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November 13, 2007

Medicare Part B Drug Competitive Acquisition Program (CAP): 2008 Physician Election Will Conclude on November 15, 2007

Medicare Part B Drug Competitive Acquisition Program (CAP): 2008 Physician Election Will Conclude on November 15, 2007

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

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

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

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

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

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

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

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

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November 14, 2007

CMS Website Difficulties

Hi everyone. I just wanted to make you aware that the Centers for Medicare and Medicaid Services (CMS) is currently experiencing some technical problems with its website. These problems are affecting many of the URLs contained in messages I have sent over the past couple of days (including last Friday). CMS is working to resolve these problems and we regret any inconvenience this might have caused you. I will notify you when the problems have been resolved and thank you for your understanding and patience.

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November 15, 2007

A Few Thursday Items and An Update on the CMS Website

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

* * * * *

Hello everyone ~ I hope you're all doing well. Just a few Thursday items for your reading enjoyment, including information on:

- Notice of Delay of Certain Provisions of Phase III in the Physician Self-Referral Regulation
- Development of Imaging Efficiency Measures
- Encore for the November 8, 2007 Hospital & Hospital Quality Open Door Forum Restored (PLEASE NOTE THAT TODAY, NOVEMBER 15TH, IS THE LAST DAY THAT THE ENCORE WILL BE AVAILABLE)
- Upcoming Reissuance of the Home Health Case Mix Grouper Software and Documentation

One important note ~ the website problems that CMS was experiencing earlier this week have been resolved. Of special interest was the link to the summary of the 2008 PQRI Medicare Physician Fee Schedule provisions. This document can be viewed at <http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMPFSSummary.pdf> . Once again, I apologize for any inconvenience.

* * * * *

CMS-1810-F2: Physician Self-Referral -- Notice of Delay of Certain Provisions of Phase III

On November 9, 2007, a final rule delaying the effective date of certain provisions of Phase III (CMS-1810-F) was made available for Public Inspection at the Office of the Federal Register. This final rule (CMS-1810-F2), which will be published in the November 15, 2007 Federal Register, delays the effective date for one year (that is, until December 4, 2008) the "stand in the shoes" provisions of the Phase III final rule as to the following compensation arrangements between the following physician organizations and entities ONLY:

-- With respect to an academic medical center as described in §411.355(e)(2), compensation arrangements between a faculty practice plan and another component of the same academic medical center; and

-- With respect to an integrated section 501(c)(3) health care system (as described in today's final rule), compensation arrangements between an affiliated DHS entity and an affiliated physician practice in the same integrated section 501(c)(3) health care system.

The final rule is available at:

http://www.cms.hhs.gov/PhysicianSelfReferral/04a_regphase3.asp .

Development of Imaging Efficiency Measures

L&M Policy Research, LLC and its partners, the National Imaging Association and the Lewin Group, have been contracted by the Centers for Medicare & Medicaid Services to develop a preliminary set of imaging efficiency measures under the project "Development of Imaging Efficiency Measures", Contract No. HHSM-500-2006-0009i/TO5. We would like to invite you to review and comment on these measures during the **30-day public comment period that began on November 13, 2007 and will close at 11:59pm on December 14, 2007**. Please note that while the team will make every effort to consider and incorporate all comments, CMS will be making all determinations on the final measure set and if or how the measures will be used in CMS program activities.

To review the measures and submit comments, please visit the following dedicated website: <http://www.imagingmeasures.com>.

We also encourage you to forward this message and link to any colleagues or organizations you feel would be interested in reviewing and commenting on the measures.

Thank you in advance for your interest. The team is looking forward to hearing from you!

Encore for the November 8, 2007 Hospital & Hospital Quality Open Door Forum Restored

CMS has been experiencing technical difficulties with accessing the November 8th Hospital & Hospital Quality Open Door Forum Encore replay. The issue has been resolved and the replay is now operating normally. To access the Encore replay for this forum, dial 1-800-642-1687 and Conference ID 18784180 followed by the “#” key. **This feature will be available until Thursday, November 15th.** We apologize for any inconvenience. Thank for your patience and your continued support of the CMS Open Door Forums.

Upcoming Reissuance of the Home Health Case Mix Grouper Software and Documentation

This notice is to alert Medicare home health agencies and software vendors of an upcoming reissuance of the Home Health Case Mix Grouper Software and Documentation. Several problems identified in the software are now being resolved.

CMS will post the corrected software on the CMS Website as soon as possible.
Corrections affect grouper software and/or pseudocode (grouper logic) as follows:

Grouper and pseudocode corrections:

- Correct the scoring of the clinical domain under certain circumstances:
 - diagnosis code is in one of the diagnosis groups referenced as either/or (e.g., line 11 of Table 5 in the pseudocode tables)
 - gangrene is paired with universally invalid etiology (e.g., V-code)
 - item M0250 (therapies received at home) has more than one response checked
- Add tests to flag invalid condition for certain diagnosis coding errors (completeness, format, or sequencing) potentially related to case mix points
 - missing decimal point in diagnosis code
 - incomplete etiology code in certain etiology/manifestation pairs
 - incomplete V-codes
 - manifestation code wrongly reported in M0246x3

Pseudocode only corrections:

- Correct error in referencing NRS array "NRS-Diag_Grps" as "NRS-Diag_Grps(SE)"
- Correct omission of NRS scoring statement for diabetic ulcers
- Correct invalidity test statement for M0476
- Assure that Skin 1 diagnosis group receives points for both rows 26 and 27 of Table 5
- Revise pseudocode tables to support tests of completeness of V-codes and etiologies

Hope you are having a good week ~ Valerie

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2008 Physician Quality Reporting Initiative (PQRI) National Provider Question & Answer Session

2008 Physician Quality Reporting Initiative (PQRI) National Provider Question & Answer Session

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group announces the first in a series of national provider conference calls on the 2008 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:00 p.m. – 5:00 p.m., EST, on Wednesday, November 28, 2007.

The call will cover the 2008 provisions of the Physician Quality Reporting Initiative that were included in the 2008 Medicare Physician Fee Schedule Final Rule. This will include a discussion of the 119 PQRI measures available for eligible professionals to select for 2008.

Information on the 2007 and 2008 PQRI programs are posted to the PQRI web page located at, <http://www.cms.hhs.gov/PQRI>, on the CMS website. The website is continually being updated, so check it often for the most current information available. There are many educational resources available on the webpage, so feel free to download the available resources prior to the call. This toll-free question and answer teleconference will provide eligible professionals the opportunity to ask questions of CMS subject matter experts.

Conference call details:

Date: November 28, 2007
Conference Title: 2008 Physician Quality Reporting Initiative National Provider Call
Time: 3:00-5:00 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, replay information is available below.

Registration will close at 3:00 p.m. EST on November 27, 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/112807>
2. Fill in all required data.
3. Verify that your time zone is displayed correctly in the drop down box.

4. Click "Register".
5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who are unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 5:30 p.m. EST 11/28/2007 until 11:59 p.m. EST 12/05/2007. The call-in data for the replay is: 800-642-1687 and the passcode is 24215922.

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

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Beneficiary-Related Information on Medicare Part D Open Enrollment

2008 Open Enrollment for Medicare Part D Prescription Drug Coverage and Medicare Advantage Plans Begins Today

Campaign Features Major Outreach to Beneficiaries Eligible for Low Income Subsidies, Enhanced Publications and Online Tools

The U.S. Department of Health and Human Services (HHS) announced that, beginning today, Medicare beneficiaries will be able to begin making enrollment changes in their health and prescription drug coverage for 2008, if necessary. The Medicare annual Open Enrollment Period for prescription drug plan runs from November 15 through December 31, 2007.

In addition, for Medicare Advantage (MA) plans only, beneficiaries can make one change in enrollment – enrolling in a new plan, changing plans or canceling a plan – between January 1 and March 31, 2008.

“Now is the time for beneficiaries to prepare and compare their health and prescription drug coverage options and choose the plan that best meets their needs,” said HHS Secretary Mike Leavitt. “We intend to keep building on the success the program has achieved thus far. The most recent satisfaction rate stands at 86 percent, the estimated average premium is 40 percent lower than originally estimated and total estimated costs are running \$188 billion below initial projections. Part D is a program that is working well and is helping Medicare beneficiaries with their prescription drug costs.”

HHS’ Centers for Medicare and Medicaid Services (CMS) encourages all beneficiaries to act soon to compare their current plan with other plan options. If they are satisfied with their current plan, they do not need to do anything in order to maintain their coverage. CMS wants eligible beneficiaries who do not have prescription drug coverage to know that, if they wait, they may pay a penalty on their premium.

During this coordinated election period, beneficiaries are encouraged to review their prescriptions and other health needs when assessing the plan options described in the “Medicare & You” handbook or on www.medicare.gov. In addition, CMS recommends that beneficiaries gather any Medicare or Social Security mailings they received and materials made available by local counselors to use as a reference when speaking with a 1-800-Medicare representative or entering information on www.medicare.gov.

CMS also encourages people to take advantage of the enhanced online Medicare Prescription Drug Plan Finder options available on www.medicare.gov. This feature offers information on available drug plans, including out-of-pocket costs and pharmacy networks. The enhanced online Medicare Prescription Drug Plan Finder and Medicare Options Compare tools enable beneficiaries to compare drug plan options for prescription drug plans and Medicare Advantage plans in their area. CMS continues to refine its educational tools, so beneficiaries will find it easier to locate information about available health and drug plans.

Starting today, www.medicare.gov also provides beneficiaries with the five-star ratings of the quality and performance of plans that offer Part C and Part D services. These plan ratings allow consumers to compare items such as customer service, complaints, managing chronic conditions and ease in obtaining prescriptions.

To read more about the plan ratings within our web compare tools, check out the CMS publication is available at <http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf> in the Medicare website.

To read more of the HHS Press release issued today click here:
<http://www.hhs.gov/news/press/2007pres/11/pr20071115a.html>

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November 20, 2007

Availability of the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC)

The following announcement is for all Medicare Fee-For-Service Providers. However, if you have association members who are DMEPOS Suppliers, please direct them to read the second announcement in this note. Thanks.

Medicare Fee-For-Service Providers: Register Now for the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC)

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available. Even though these new internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

A recent MLN Matters article, the first in a new series on IACS-PC, addresses key questions and answers about the registration process and can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS website.

FYI – DMEPOS Suppliers Should Not Register Now for the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC)

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available. Although CMS recently announced that Medicare FFS providers should now register for IACS-PC, CMS does not expect that any new online services will be available to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers in 2008. **Therefore, DMEPOS suppliers should not register for IACS-PC at this time.** DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions, which will be released closer to the 2008 bid window.

To learn more about IACS-PC in preparation for future registration, see the new MLN Matters article (the first in a new series on IACS-PC) which addresses key questions and answers about the registration process. The article is now available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS website.

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November 23, 2007

National Influenza Vaccination Week

November 26 – December 2, 2007 is National Influenza Vaccination Week. The Centers for Disease Control and Prevention has designated the week after Thanksgiving as ***National Influenza Vaccination Week***. This week long event is designed to raise awareness of the importance of continuing influenza (flu) vaccination, as well as foster greater use of flu vaccine through the months of November, December and beyond. Since flu activity typically does not peak until February or later, November and December still provide good opportunities to offer flu shots. Although Medicare provides coverage for the flu vaccine and its administration, there are still many beneficiaries who don't take advantage of this benefit. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu shot. If you have Medicare patients who have not yet received their annual flu shot, we ask that you encourage these patients to protect themselves from the seasonal flu and serious complications arising from the flu virus by recommending that they take advantage of the annual flu shot benefit covered by Medicare. – And remember, health care professionals and their staff are also at risk for contracting the flu, so don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot -- Not the Flu!**

NOTE: - Influenza vaccination is a covered Part B benefit; however, the influenza vaccine is NOT a Part D covered drug.

For More Information

CMS has developed a variety of educational resources for health care professionals and their staff to assist with understanding coverage, coding, and billing of adult immunizations covered by Medicare. To learn more, please refer to *MLN Matters* article SE0748 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf> on the CMS website.

For more information about National Influenza Vaccination Week, please visit the Centers for Disease Control and Prevention, <http://www.cdc.gov/flu/nivw/>, on the Web.

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

November 27, 2007

Your Latest NPI Update ~ Information on Reporting SSNs, Proper Placement of Medicare Legacy IDs in NPES, and Much More!

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

Social Security Numbers (SSNs) Should Not Be Reported in FOIA-disclosable NPES Fields

As CMS has mentioned in previous outreach messages and on the CMS NPI website, some health care providers have reported their Social Security Numbers (SSNs), or the SSNs of other health care providers, in their NPES records in fields that the Freedom of Information Act (FOIA) requires that CMS make publicly available. For example, there are instances where SSNs are reported in the "Other Provider Identification Numbers," "License Number," and "Employer Identification Number (EIN)" fields in providers' NPES records. The information that providers report in these (and certain other) fields is fully disclosable by CMS to the public and, therefore, **SSNs should never be reported in any of these fields.**

Because SSNs are 9-digit numbers, CMS has been suppressing all 9-digit numbers found in any FOIA-disclosable field except for ZIP code and telephone/fax number fields. This means that these 9-digit numbers—whether or not they are SSNs—are not displayed in the NPI Registry and cannot be found in the monthly NPES downloadable file. If these 9-digit numbers are legitimate EINs, "Other Provider Identification Numbers," or "License Numbers," health plans and others who are using the NPI Registry and the downloadable file are not able to see them, which means that they cannot see all of the NPES data they may need in order to accurately match providers in NPES to the providers in their own files, thus making it more difficult to link NPIs to legacy identifiers. In some cases, this may adversely affect payments to providers by health plans.

It is imperative that providers immediately look at their NPES records to ensure that they did not inadvertently report their, or someone else's, SSN in a FOIA-disclosable field; if they did, they need to delete that SSN immediately and, if appropriate, replace it with the correct information (e.g., an EIN). Providers must look in their NPES records (<https://npes.cms.hhs.gov/>) in order to view all of the information they reported. If they need assistance in deleting inappropriately reported SSNs, they may contact the NPI Enumerator at 1-800-465-3203. If they need assistance in knowing which NPES fields are disclosable under FOIA, they should review the document entitled, "National Plan and Provider Enumeration System (NPES) Data Elements Data Dissemination – Information for Providers," dated June 20, 2007, and found at http://www.cms.hhs.gov/NationalProviderStand/Downloads/NPES_FOIA_Data%20Elements_062007.pdf on the CMS NPI web page.

Providers cannot rely on the information disclosed in the NPI Registry or in the downloadable file in trying to determine if they inappropriately reported SSNs in FOIA-disclosable fields because CMS suppresses these numbers, as explained above; these numbers will not be seen in the NPI Registry or the downloadable file.

In order to protect your personal information from public disclosure, please correct this information immediately if this situation pertains to you.

When to Contact the NPI Enumerator for Assistance

The topics with which the NPI Enumerator can assist providers are listed below:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate

- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing assistance on any of the above topics may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

The NPI application form, itself, is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update an NPES record. Refer to the 'Application Help' tab located on the NPES website for additional assistance while online.

Important Information for Medicare Providers

As of 10/29/07 all Medicare contractors have lifted the bypass logic and are editing against the Medicare crosswalk. As a result, claims that include non-matching NPIs and legacy identifiers are now rejecting. The following table is a review of the next set of dates which are crucial for compliance with the NPI regulations.

Medicare's Key Dates

Date	Implementation Steps
January 1, 2008	<ul style="list-style-type: none"> - 837I electronic claims and UB-04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. - Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields.
March 1, 2008	<ul style="list-style-type: none"> - Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). - You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. - Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable. - Until further notice, you may continue to include legacy identifiers only for the provider secondary fields.
May 23, 2008	<ul style="list-style-type: none"> - In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. - This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. - CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Be Sure to List Medicare Legacy Identifiers in the Appropriate Fields in NPPES!

It is important for Medicare providers to note that the Medicare crosswalk only uses numbers listed in the **Medicare fields within the “Other Provider Identification Numbers” section** of the NPPES application; this section has fields for Medicare UPIN, Medicare OSCAR/Certification, Medicare PIN and Medicare NSC as noted in the following sample of the section:

<u>Issuer</u>	<u>Number</u>	<u>State</u>	<u>Issuer (for Other Number Type only)</u>
Medicare UPIN			
Medicare Oscar/Certification			
Medicare PIN			
Medicare NSC			
Medicaid		State is required if Medicaid number is furnished	
Other, Specify:			

If claims are rejecting, providers should review their NPPES records (not their NPI Registry records), to confirm that Medicare legacy identifiers are reported in the appropriate fields of the “Other Provider Identification Numbers” section.

Correct Way to List a Railroad Retirement (RR) Number in NPPES

It has come to our attention that certain clearinghouses are incorrectly instructing Medicare providers who bill as part of the Railroad Retirement (RR) Board program to list their Medicare RR PIN in the “Other” section in the “Other Provider Identification Numbers” field of NPPES (see the diagram in the above paragraph to view a sample of this NPPES field). An RR PIN is a Medicare PIN, and, therefore, should be listed in the Medicare PIN section within this field of NPPES. RR providers should double check their NPPES records and update their information, if necessary. Because Medicare RR PINs are 9-digit numbers, they are temporarily being suppressed and will not be displayed in the NPI Registry or the downloadable file. Providers should review their NPPES records, not their NPI Registry records, to determine if corrections are needed.

What is meant by the Term “Billing Provider”?

The term “Billing Provider” means the provider that is identified in the following loops, field locators, or items in the 837I/UB-04 and the 837P/CMS-1500 claim formats, respectively. Although the name of this loop/segment is “Billing Provider”, the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop.

Institutional Claims

- 837I (electronic claim)
 - Billing Provider 2010AA
- UB-04 (paper claim)
 - Form Locator (FL) 01

Professional Claims

- 837P (electronic claim)
 - Billing Provider 2010AA
- CMS-1500 (paper claim)
 - Field 33

Test Your Claims Now!

Medicare also continues to urge providers to send a small batch of claims now with only the NPI. If the results are positive, begin increasing the number of claims in the batch.

If claims are rejecting, first go into the NPPES website located at <https://nppes.cms.hhs.gov/> and validate that your NPPES information is correct and that you reported your Medicare legacy identifier(s) in the appropriate Medicare sections of the "Other Provider Identification Numbers" field. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the information in your NPPES record is correct and you reported your Medicare legacy identifier(s), print the screen (so you have a copy of your NPPES record on paper), call your contractor and ask they validate what is in their system.

Reminder: Medicare Is Issuing Informational Warnings to Those Who Are Not Submitting NPIs On Part B Claims

As stated in an earlier November NPI message, since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) **using the ASC X12N 837P** receive informational warnings that indicate if there was no NPI shown in the primary provider fields in those claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, 2008, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers. By doing so, you should have sufficient time to correct any problems that came about prior to the requirement to use only the NPI in claims.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

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

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Outreach Events Regarding PQRI & HAC and POA Indicator Initiative

Reminder ~ 2008 Physician Quality Reporting Initiative (PQRI) National Provider Conference Call with Question & Answer Session

Registration for the call closes at 3:00 pm EST on November 27th, 2007. If you have a problem accessing the URL embedded in this message, please cut and paste the registration URL into your internet browser.

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group announces the first in a series of national provider conference calls on the 2008

Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:00 p.m. – 5:00 p.m., EST, on Wednesday, November 28, 2007.

The call will cover the 2008 provisions of the Physician Quality Reporting Initiative that were included in the 2008 Medicare Physician Fee Schedule Final Rule. This will include a discussion of the 119 PQRI measures available for eligible professionals to select for 2008.

Registration will close at 3:00 p.m. EST on November 27, 2007, or when available space has been filled. No exceptions will be made so please be sure to register prior to this time.

Conference call details:

Date: November 28, 2007
Conference Title: 2008 Physician Quality Reporting Initiative National Provider Call
Time: 3:00-5:00 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, replay information is available below.

1. To register for the call participants need to go to:
<http://www2.eventsvc.com/palmettogba/112807>
2. Fill in all required data.
3. Verify that your time zone is displayed correctly in the drop down box.
4. Click "Register".
5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of you who are unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 5:30 p.m. EST, 11/28/2007 until 11:59 p.m. EST 12/05/2007. The call-in data for the replay is: 800-642-1687 and the passcode is 24215922.

Listening Session on Hospital-Acquired Conditions and Present on Admission Indicator Initiative

The Center for Medicare & Medicaid Services (CMS) announces, via a *Federal Register* Notice, a Hospital-Acquired Conditions (HAC) & Present On Admission (POA) Listening Session to be held on **Monday, December 17, 2007**. For more information, including registration requirements and submission of comments process, and to read the notice in full, please use the following link:

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5801.pdf>

For the most up-to-date information on the Hospital-Acquired Conditions and Present on Admission Indicator initiative, please visit, <http://www.cms.hhs.gov/HospitalAcqCond/>, on the CMS website.

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November 29, 2007

A Reminder for Part A Home Health Providers

The Centers for Medicare & Medicaid Services (CMS) would like to remind Part A Home Health providers that home health agencies must take certain actions with regard to the collection and reporting of the Outcome and Assessment Information Set (OASIS) data for their Medicare beneficiaries in order to be reimbursed under the updated payment system effective January 1, 2008.

Assistance in the transition phase is available in documents addressing the last 5 days in December for the PPS update. Please click on the following links, <http://www.cms.hhs.gov/OASIS/Downloads/OASISConsiderationsforPPS.pdf> and <http://www.cms.hhs.gov/HomeHealthPPS/Downloads/TransitionEpisodesQA.pdf>, on the CMS Website for further clarification. In addition, feel free to visit the OASIS webpage at <http://www.cms.hhs.gov/oasis>, on the CMS website for the most update information.

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November 30, 2007

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

* * * * *

Happy Friday everyone ~ I hope you had a good week. Items in today's message include information on:

- Countdown Underway for Current Medicare-Approved Organ Transplant Centers to Request Certification Under the New Rule
- HHS Reports to Congress on Value-Based Purchasing of Hospital Services by Medicare
- Online/Interactive Workshops Regarding the Physician CAP for Part B Drugs and Biologicals Updates Regarding the Medicare Part B Drug Competitive Acquisition Program (CAP)



- New from the Medicare Learning Network
- Medicare Diabetes Coverage
- Beneficiary-Related News on Nursing Homes and Hospitals
- Flu Shot Reminder

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

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

submitted to CMS **by DECEMBER 26, 2007** (180 days from the effective date of the regulation).

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

There is no application form. Transplant centers must send a request (e.g. a letter) to CMS with specific information. For a list of all transplant centers covered by the regulation and a listing of the minimum information that must be included in all requests to CMS for approval of your transplant center, please visit our transplant web page at: http://www.cms.hhs.gov/CertificationandCompliance/20_Transplant.asp

Transplant centers desiring first time Medicare certification must send a request to CMS with the same information. This can be done any time the center is ready for initial Medicare certification.

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

HHS Reports to Congress on Value-Based Purchasing of Hospital Services by Medicare

The Secretary of Health and Human Services has delivered to Congress a Report on the Medicare Hospital Value-Based Purchasing Program (VBP), suggesting ways to continue transforming Medicare into a prudent purchaser of higher quality health care for Medicare beneficiaries.

“For Medicare beneficiaries to get higher quality health care, our payment system needs to encourage better care,” said HHS Secretary Mike Leavitt. “Paying hospitals for the quality of care they provide takes us closer to that goal.”

“Value-based purchasing would benefit Medicare beneficiaries and other health care consumers by encouraging higher quality hospital care,” said Kerry Weems, acting administrator of the Centers for Medicare & Medicaid Services (CMS). “Under the plan, additional information would be collected and publicly disseminated to patients and health care providers so that they can make better health care decisions.”

To view the entire press release, please click here:
<http://www.hhs.gov/news/press/2007pres/2007.html>

Online/Interactive Workshops Regarding the Physician Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals

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:

- 12/12/07 at 2:00 pm Central Standard Time
- 1/15/08 at 2:00 pm Central Standard Time



New from the Medicare Learning Network

The Medicare Learning Network has updated the following web-based (WBT) training course: ***Medicare Preventive Services Series: Part 3 Expanded Benefits***. This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as, the "Welcome to Medicare" physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements. Note: CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit, http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

Medicare Diabetes Coverage

American Diabetes Month is just about over, but the importance of talking with your Medicare patients about the seriousness of diabetes, their risk factors for the disease, and the importance of early detection and treatment remains, as millions of people in the United States are living with diabetes and don't know it. Together, we can make a

difference in the lives of people with Medicare by encouraging eligible beneficiaries to take advantage of the diabetes screening services covered by Medicare. And we can help those already diagnosed with diabetes manage their condition by recommending diabetes self-management training and medical nutrition therapy services, also covered by Medicare.

To Learn More

Health care providers and their staff can learn more about Medicare's coverage of diabetes screening tests, supplies and other services for beneficiaries with diabetes, including coding, billing, and reimbursement details, by referring to the following provider education resources:

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*
http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- *Diabetes-Related Services* brochure
<http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvc.pdf>
- National Diabetes Education Program (NDEP) <http://ndep.nih.gov/>
- Educational literature for beneficiaries <http://www.medicare.gov>

Thank you for helping CMS spread the word about the importance of diabetes education and the benefits covered by Medicare for the early detection and treatment of diabetes.

Beneficiary-Related News

CMS Publishes National List of Poor-Performing Nursing Homes, Key Tool for Families Seeking Quality Care

The Centers for Medicare & Medicaid Services (CMS) released the first ranking of the nation's poor-performing nursing homes. Release of the national list of facilities, identified as special focus facilities (SFFs), is expected to offer individuals seeking long-term health care services, and their families, powerful new information when choosing nursing homes.

"Nearly three million Americans, most of who are enrolled in Medicare or Medicaid, depend on the nation's 16,000 nursing homes at some point during each year to provide life-saving care," said CMS Acting Administrator Kerry Weems. "Release of this national list of special focus facilities reinforces CMS' commitment to provide beneficiaries and their families the information they need when making long-term care choices."

Release of the list was prompted by the number of facilities that were consistently providing poor quality of care, yet were periodically instituting enough improvement that they would pass one survey only to fail the next (for many of the same problems as before). Such facilities with a “yo-yo” compliance history rarely addressed underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

Once a facility is selected as an SFF, the state survey agency conducts twice the number of standard surveys and will apply progressive enforcement until the nursing home either (a) significantly improves and is no longer identified as an SFF, (b) is granted additional time due to promising developments, or (c) is terminated from Medicare and/or Medicaid. CMS and the state can more quickly terminate a facility that is placing residents in immediate jeopardy.

The CMS policy of progressive enforcement means that any nursing home, not just those identified as an SFF, that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action. If problems continue, the severity of penalties will increase over time, ranging from civil monetary penalties, denial of payment for new admissions and, ultimately, removal from Medicare and/or Medicaid.

As of October 2007, there were 128 SFFs, out of about 16,000 active nursing homes. The number of SFFs in each state varies according to the number of nursing homes in the state. These nursing homes, at the time of their selection as an SFF, had survey results that were among the poorest five or 10 percent in each state.

Today’s list includes 54 facilities that are at the top of the poorest performers in those states and among those facilities that have failed to improve significantly.

Typically, these facilities achieve improved survey results after being selected for the initiative. The CMS data indicate that about 50 percent of the nursing homes identified as SFFs significantly improve their quality of care within 24-30 months, while about 16 percent are terminated from Medicare and Medicaid.

In addition to publishing the list of SFFs, CMS is taking many other steps to improve the quality of care in the nation’s nursing homes including a new program that will make the payment system more sensitive to quality improvements; developing new, more stringent systems for criminal background checks on facility workers and applicants; unprecedented focus on preventing catastrophic pressure ulcers in nursing home residents; and improving the state survey process.

“CMS’ effort to identify poor performing nursing homes is intended to promote more rapid and substantial improvement in the quality of care in identified nursing homes and end the pattern of repeated cycles of non-compliance,” Weems noted.

In addition to consulting the CMS list of SFFs found on http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp, beneficiaries and their families looking for a nursing home should take other steps including:

- Visit the nursing home. Talk to staff, residents, and other families. Request to see the results from the last state or CMS survey.
- Prior to a visit, review the survey history of the nursing home on *Nursing Home Compare* to better understand any areas that may be problematic.
- Ask the nursing home staff what they are doing to improve the quality of care for residents in the nursing home.
- Call the state survey agency to learn more about the nursing home. If the facility is in the special focus initiative, find out how long it has participated. Facilities in the program for 18-24 months are either close to “graduating” because of significant improvements to care, or ending their participation in Medicare and Medicaid.
- Call your local state nursing home ombudsman, Administration on Aging, and local groups to learn more about the nursing home.
- Use the Nursing Home Brochure <http://www.medicare.gov/Publications/Pubs/pdf/nursinghome.pdf> and “Guide to Choosing a Nursing Home” <http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf> - both publications are available on *Nursing Home Compare*.

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HCAHPS: The Patient’s Perspective on Hospital Care

The first national, standardized survey of patients' perspectives of hospital care, the CAHPS® Hospital Survey (better known as **HCAHPS**), has now been in the field for over a year, and results for the ~2,700 participating hospitals will be publicly reported for the first time in March 2008.

HCAHPS has already caught the attention of many healthcare organizations and hospital administrators, and it is quite possible that, armed with survey results for one or more hospitals, patients soon will be soliciting your advice.

The survey, which asks a random sample of discharged, adult patients across medical conditions about their experience of care (including communication with doctors) and rating of hospital, was developed by researchers at the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS), who also oversees survey administration and public reporting.

Participating hospitals (and by 2009 nearly all acute care hospitals will participate or risk losing significant government payments) must adhere to standardized survey administration protocols and submit to government review. Hospital-level scores will be publicly reported on the *Hospital Compare* website (www.hospitalcompare.hhs.gov), alongside the current clinical and mortality measures. Results will be adjusted for survey mode (mail, telephone, etc.) and patient characteristics (self-reported health status, age, ER admission, etc.) to eliminate sources of potential bias.

If you are curious, the 27 items on the HCAHPS survey can be viewed at <http://www.hcahpsonline.org/surveyinstrument.aspx>. The official HCAHPS website, www.hcahpsonline.org, also houses a wealth of information about survey content, development, and administration.

FLU SHOT REMINDER

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

I hope you enjoy a wonderful weekend!

With best regards ~ Valerie

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