CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 339 **Date: OCTOBER 27, 2004**

CHANGE REQUEST 3442

NOTE: These instructions were previously released under RO-2907 dated October 27, 2004, with instructions not to post until you receive further guidance from CMS. These instructions are no longer Sensitive and can now be posted to your Intranet and Internet.

SUBJECT: Calendar Year (CY) 2005 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. SUMMARY OF CHANGES: Carriers conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with the opportunity to enroll in, or terminate enrollment from, the participation program. This instruction furnishes carriers with the materials needed for the 2005 participation enrollment effort.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 27, 2004
IMPLEMENTATION DATE: November 10, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 339	Date: November 17, 2004	Change Request 3442

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SUBJECT: Calendar Year (CY) 2005 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. GENERAL INFORMATION

A. Background: Carriers conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision by December 31. To sign a participating agreement is to agree to accept assignment for all covered services that are provided to Medicare patients. After the enrollment period ends, carriers publish an updated list of participating physicians, practitioners, and suppliers, in the MEDPARD.

B. Policy: The annual participation enrollment program for CY 2005 will commence on November 15, 2004, and will run through December 31, 2004.

The purpose of this Recurring Update Notification is to furnish carriers with material needed for the CY 2005 participation enrollment effort. The following documents will be attached in the final CR:

- A Participation Announcement;
- A Blank Participation Agreement; and
- A Year 2005 Fact Sheet.

This year, carriers shall produce and mail the Participation Enrollment and disclosure information on a CD-ROM (refer to Change Request 3292). The information contained in this Recurring Update Notification and the CY 2005 Fact Sheet must be kept CONFIDENTIAL until the Physician Fee Schedule Final Rule is put on display. The Fact Sheet is subject to change during the regulation clearance process. We will send all contractors an e-mail notice when the Physician Fee Schedule Final Rule has been put on display, and we will notify the regional offices if any information in the Fact Sheet changes during the clearance process. Participation enrollment/fee disclosure packages should be mailed in time for physicians, practitioners, and suppliers, to receive the material by November 15, but it should not be mailed before November 10.

Physicians, practitioners, and suppliers, enrolled in the Medicare program and who chose not to accept assignment for every covered service they furnish do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment.

The CMS plans to release the Medicare Physician Fee Schedule Database (MPFSDB) and the anesthesia conversion factors to carriers electronically in mid to late October. This data must also be kept confidential until the physician fee schedule final rule is put on display.

C. Provider Education: None. There will not be a Medlearn Matters article. Releasing the entire participation enrollment/fee schedule disclosure package and posting of the MEDPARD information is considered provider education. Carriers shall follow the instructions regarding the dates for releasing/mailing these materials that are contained in this Recurring Update Notification.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FISS	RHHI	Car r ier	DMERC	F I SS	MCS	VMS	CWF	
3442.1	Carriers shall reproduce the attachments for the participation enrollment/fee disclosure material. (See Publication 100-04, chapter 1, section 30.3.12.) For CY 2005 disclosure reports, display fee data as follows: • Procedure code (including professional and technical component modifiers, as applicable); • Par amount (non-facility); • Par amount (facility-based); • Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); and • Limiting charge (facility-based).			X						
3442.1.1	Carriers shall insert their carrier-specific information (i.e., toll-free telephone numbers) in the blank lines as indicated at the end of the Participation Announcement sheet.			X						
3442.2	Carriers shall produce and mail the disclosure information on a CD-ROM. Carriers shall also produce no more than 2% hard copy disclosures (refer to CR 3292).			X						
3442.3	For CY 2005 disclosure reports, carriers shall provide the anesthesia conversion factors.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FISS	RHHI	Car r ier	DMERC	F I SS	MCS	VMS	CWF	
3442.4	Carriers shall annotate the envelope containing the fee disclosure material with the following message: "Open Immediately. Package Contains 2005 Medicare Payment Information from the Centers for Medicare & Medicaid Services." **Note:** Carriers may use: "Open Immediately. Package Contains 2005 Medicare Payment Information from CMS." on the envelope, if it is helpful to do so. However, carriers that use this message must be sure the CMS logo is also on the envelope.			X						
3442.5	Mail participation enrollment/fee disclosure materials via first class or equivalent delivery service, and schedule the release of these materials so that providers receive it no later than November 15, 2004, but do not mail it before November 10, 2004.			X						
3442.6	The MPFSDB will contain the CY 2005 fee schedule amounts. Carriers shall include fee amounts for procedure codes with status indicators of A, T, and R (if Relative Value Units (RVUs) have been established by CMS) in their disclosure reports. The following two statements must be included on the fee disclosure reports: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted by the American Medical Association." "These amounts apply when service is performed in a facility setting." (This statement should be made applicable to those services subject to a differential based on place of service.)			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FISS	RHHI	Car r ier	DMERC	F I SS	MCS	VMS	CWF	
3442.7	In addition to sending disclosure reports in the participation enrollment material, you may, at your discretion, and within the constraints of your authorized budget, load the fees on your Internet Web site. (**Note:** The fees shall not be loaded on the Web site prior to the release of the material sent out by mail). If you choose to use code descriptors on your Web site you must use the short descriptors contained in the Healthcare Common Procedure Coding System (HCPCS) file and the MPFSDB. If you find descriptor discrepancies between these two files, use the HCPCS file short descriptor. The CMS has signed agreements with the American Medical Association regarding use of CPT, and the American Dental Association regarding use of Current Dental Terminology (CDT), on Medicare contractor Web sites, CD-ROMs, bulletin boards, and other electronic communications (refer to the Publication 100-4, chapter 23, section 20.7).			X						
3442.8	Carriers shall process participation elections and withdraws post-marked before January 1.			X						
3442.9	Do not print hardcopy participation directories (i.e., MEDPARDs) for CY 2005 without regional office prior authorization and advanced approved funding for this purpose. Supplemental budget requests (SBRs) for CY 2005 MEDPARD directories will not be approved.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FISS	RHHI	Car r ier	DMERC	F I SS	MCS	VMS	CWF	
3442.9.1	If you receive inquiries from a customer who does not have access to your Web site, ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via phone or letter.			X						
3442.10	Load MEDPARD-equivalent information on your Internet Web site by the end of January.			X						
3442.11	Notify providers via regularly scheduled newsletter as to the availability of the MEDPARD information and how to access it electronically. Also, inform hospitals and other organizations (i.e., Social Security offices, area administration on aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on your Web site.			X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: This Recurring Update Notification is dependent upon the release of the Physician Fee Schedule regulation.

F. Testing Considerations: N/A

IV. ATTACHMENT(S), SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 27, 2004 **Implementation Date:** November 10, 2004 **Pre-Implementation Contact(s):** Kathy Kersell, (410) 786-2033, kkersell@cms.hhs.gov**;** and April Billingsley, (410) 786-0140, abillingsley@cms.hhs.gov **Post-Implementation Contact(s): Appropriate regional office.**	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

3 Attachments: Participation Announcement;
Blank Participation Agreement; and
Year 2005 Fact Sheet.

CENTERS for MEDICARE & MEDICAID SERVICES

Announcement

About Medicare Participation for Calendar Year 2005

The new year promises to be an exciting year for the Medicare Program, especially for beneficiaries and the physicians, providers, and suppliers which serve them. Your commitment to Medicare sustains an important lifeline to millions of seniors, disabled, and individuals with end-stage renal disease. The 2005 calendar year introduces new and important program initiatives resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As part of ongoing efforts to modernize Medicare, new benefits available in 2005 will help Medicare beneficiaries stay healthier and get better access to important preventive medical services. The new preventive benefits, which were authorized by the MMA, are the heart of the initiative to make Medicare a modern prevention-focused program. Central to the initiative is the "Welcome to Medicare Physical," an initial preventive examination for all new Medicare beneficiaries. The new law also provides new Medicare coverage for cardiovascular screening blood tests for the detection of cardiovascular disease or related abnormalities and coverage for diabetes screening tests for beneficiaries identified as at-risk for this illness.

Another important change for 2005 will provide a 5 percent incentive payment to both primary care and specialty physicians furnishing services to beneficiaries in those areas with low ratios of physicians to beneficiaries. These payments will be in addition to the 10 percent bonus provided to those physicians providing services in "health professional shortage areas." In most cases, Medicare will make these payments automatically so the physician will not have to take any special action to receive the additional payments.

The Medicare-Approved Drug Discount Cards are available for people with Medicare who need help with drug coverage. In addition to drug prices that are 20 percent or more lower than retail prices, beneficiaries with limited incomes who are struggling with their prescription drug costs may also be eligible for a $600 credit to help pay for their medicines in 2005, plus substantial additional manufacturer discounts. We encourage you to promote the Medicare drug card program with your patients, especially those who are paying for their drugs out of their own pockets. People with Medicare can learn how to sign up and find the best card for them by calling 1-800-MEDICARE, by visiting www.medicare.gov, or by calling their local State Health Insurance and Assistance Program.

We are also pleased that Medicare will be increasing physician fee schedule rates by an average of 1.5 percent in 2005. Unlike prior years where a formula in the law required Medicare to reduce physician fee schedule rates, Congress and the Administration worked hard to ensure that the law would replace a projected update of minus 3.7 percent for 2005 with a 1.5 percent average increase.

All physicians, practitioners and suppliers must make their calendar year (CY) 2005 Medicare participation decision by December 31, 2004.

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2005.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have non-employment-related Medigap coverage and who assign both their Medicare and Medigap payments to participants. After we have made payment, we automatically send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

The majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2004, 90.3 percent of all physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHAT TO DO

If you choose to be a participant in CY 2005:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement enclosed and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in CY 2005:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective January 1, 2005. This written notice must be postmarked prior to January 1, 2005.

Hold onto this announcement during this enrollment period. You may want to refer to it again before making your decision regarding Medicare participation for CY 2005.

We hope you will decide to be a Medicare participant in CY 2005.

Please call _____ if you have any questions or need further information on participation.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various carrier contacts including the carrier medical directors, please visit the CMS web site at http://www.cms.hhs.gov/.

For ____(carrier name)_____, you may contact the following toll-free number(s) for assistance:

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*

Physician or Supplier Identification Code(s)*

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective _____.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

_____	_____	_____
Signature of participant (or authorized representative of participating organization)	Title (if signer is authorized representative of organization)	Date

(including area code)
Office phone number

*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

CMS-460 (10/02)

Received by
(name of carrier)

Effective date

Initials of carrier official

KEY NEWS FROM MEDICARE FOR 2005

FOR PHYSICIANS AND OTHER PROVIDERS

Billing and business staff: Share this with physicians and other providers.

Physician Fee Schedule Information

In the August 5, 2004, *Federal Register,* the Center for Medicare & Medicaid Services *(*CMS) published the following proposed rule: Revisions to Payment Polices Under the Physician Fee Schedule for Calendar Year 2005. This proposed rule contained a number of changes affecting physicians that result from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Included among these MMA provisions are: the "Welcome to Medicare" preventive physical examination for new beneficiaries; a new cardiovascular screening blood test benefit; a new diabetes screening benefit; incentive payment improvements for physicians practicing in physician shortage areas; and changes to the drug payment methodology. We also proposed other non-MMA policy changes. Our final polices will be published in the final rule in early November.

General Medicare News

1. The Centers for Medicare & Medicaid Services (CMS) is Trying to Make Your Life Easier

The CMS has two initiatives focusing exclusively on physician and provider/supplier issues concerning the Medicare program. The Open Door initiative conducts monthly conference calls open to everyone in which providers discuss their issues with senior Medicare officials, questions are answered and problems are addressed in real time. More information is available at http://www.cms.hhs.gov/opendoor/. The Physicians Regulatory Issues Team (PRIT) is another initiative with a single task, to address the regulatory burden which providers may confront in dealing with Medicare. The PRIT welcomes issues and input from physicians and other providers. The team can be reached by sending an email to http://www.PRIT@cms.hhs.gov.

2. Medicare-Approved Drug Discount Card Program

Medicare beneficiaries, who don't have outpatient prescription drug coverage through Medicaid, can still get help with their outpatient prescription costs through a Medicare-approved drug discount card. The program, which started in the Spring of 2004, will continue through December 31, 2005. Medicare's new prescription drug benefit begins on January 1, 2006. For a small annual enrollment fee, these cards can help your Medicare patients save 11-18 percent over national average retail prices for drugs commonly used by the Medicare population. Low-income beneficiaries receive additional assistance and can save 32 to 86 percent when both the discounts and $600 in transitional assistance is taken into account. Several brand name

pharmaceutical manufacturers have additional programs for low-income beneficiaries that can provide substantially more savings.

To obtain more information, please refer your patients to:

- Call 1-800-MEDICARE (1-800-633-4227) and ask about drug savings. TTY users should call 1-877-486-2048; or
- Access www.medicare.gov on the web (select "Prescription Drug and Other Assistance Programs.").

3. Competitive Acquisition Program for Medicare Part B Drugs

Section 303(d) of the MMA of 2003 requires the implementation of a competitive acquisition program for Medicare Part B drugs not paid on a cost or prospective payment system basis. Under the new program, which is scheduled for implementation on January 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or selecting a Medicare-approved vendor that will supply these drugs. If the physician elects to obtain drugs through the competitive acquisition program, the vendor will bill Medicare for the drug. The vendor will also bill the beneficiary for any applicable coinsurance and deductible.

Annual physician enrollment in the program is anticipated to begin in the fall of 2005. The following web site is being constructed in order to keep physicians informed about enrollment procedures, drug vendors, and drugs that may be obtained through the program: **www.cms.hhs.gov/providers/drugs/compbid**. The CMS is also interested in receiving public comments about the competitive acquisition program; general comments may be submitted to the following e-mail address: **MMA303dDrugBid@cms.hhs.gov**

4. New Medicare Preventive Services

Effective January 1, 2005, under the MMA, Medicare will provide coverage for three new preventive services. These new preventive services include coverage for an initial preventive physical examination, coverage for cardiovascular screening blood tests, and coverage of diabetes screening tests. While Medicare already provides coverage for many different preventive services, these new services expand the scope of beneficial medical screening services to Medicare beneficiaries.

The CMS will launch an educational campaign to inform you and other providers about these new benefits, ask for your assistance with informing beneficiaries about these services, and direct you and your patients to resources as they become available. Information about coverage, billing, and coding procedures for these new services are also forthcoming.

5. Incentive Payment Improvements for Physicians in Shortage Areas

Effective January 1, 2005, Section 413 of the MMA provides for an additional payment to physicians in counties where there is a scarcity of physicians (Physician Scarcity Area—PSA).

The MMA also provides for improvements to the health professional shortage area (HPSA) incentive payment.

The CMS has created a user friendly Web page for the provider community that addresses the changes to the HPSA bonus payment program and describes the new PSA bonus payment program. The Web page provides a high level overview of both bonus payment programs, complete instructions on determining eligibility for the automated payments, and helpful resources with links to further assist physicians in completing a bonus payment claim. The new procedures are effective for claims submitted with dates of service on and after January 1, 2005. The Web site is http://www.cms.hhs.gov/providers/bonuspayment.

6. Payment for Influenza and Pneumococcal Vaccines

The CMS increased the Medicare payment rate for influenza and pneumococcal vaccines. The influenza vaccine payment increased to $10.10 and the pneumococcal vaccine payment increased to $23.28. The new vaccine payment amounts were effective September 1, 2004. As always, the CMS urges you to place your vaccine orders early to ensure timely receipt.

7. HIPAA Message for Medicare Providers:

As you are aware, October 16, 2003, was the deadline for compliance with the electronic transaction and code set standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the vast majority of Medicare providers are in compliance with the HIPAA standards, there still remains some work to be done to get all electronic billing Medicare providers into compliance. To be in compliance with the law, it is critical that every Medicare electronic billing provider be submitting HIPAA compliant claims.

If you need assistance with submitting HIPAA compliant claims, we welcome the opportunity to work with you. Contact your Medicare contractor for assistance or you may contact your regional office for help.

In our efforts to keep you informed about HIPAA issues, we encourage you to visit the following Web pages for the latest news affecting you. To access our national educational articles, distributed as part of the *Medlearn Matters* process, visit http://www.cms.hhs.gov/medlearn/matters/. To access a variety of issues related to HIPAA policies affecting Medicare providers, visit http://www.cms.hhs.gov/providers/edi/.

8. HIPAA Security Compliance Deadline

By April 21, 2005, all covered entities under the HIPAA (except small health plans) must ensure the security of electronic protected health information. Small health plans have until April 21, 2006, to meet the HIPAA security standards. The CMS has released the HIPAA Security Rule which outlines the administrative, physical and technical safeguards that a covered entity must implement to be in compliance with the HIPAA security standards. A copy of the rule may be downloaded from the CMS Web site at: hhtp:/www.cms.hhs.gov/hipaa/hipaa2.

The security requirements were designed to be technology neutral and scalable from the very largest of health plans to the very smallest of provider practices. Covered entities will find that compliance with the Security Rule will require an evaluation of what security measures are currently in place, an in-depth risk analysis, and a series of documented solutions derived from a number of complex factors unique to each organization.

The CMS is eager to help you understand and implement the strategies for complying with the Security Rule and is developing a wealth of educational materials that will be available on the CMS Web site, located at http://www.cms.hhs.gov/hipaa/hipaa2. In addition, there are a number of professional and standard setting organizations that offer listservs, white papers, and other helpful resources on security implementation.

9. Medicare and You 2005

The national edition of Medicare and You 2005 is available for order after October 4, 2004. Call 1-800-MEDICARE (1-800-633-4227) to request up to 25 copies, or fax an order to 410-786-1905 for more than 25 copies.

10. Advance Beneficiary Notices (ABNs)

The ABN standard form, CMS-R-131, is available on the Beneficiary Notices Initiative (BNI) Web site. For replicable ABN forms and information on how to properly use the ABN, please visit the BNI Web site at http://cms.hhs.gov/medicare/bni.

11. Relevant Medicare Patient Brochures That May Be Of Interest To Physicians

There are a variety of new and revised brochures that physicians might find helpful to address frequently asked coverage-related questions. These include: Does Your Doctor or Supplier Accept Assignment? (CMS Publication # 10134); How to Read Your Medicare Summary Notice (CMS Publication # 11055); Medicare Coverage of Durable Medical Equipment (CMS Publication # 11045); Medicare Coverage of ambulance Services (CMS Publication #11021); Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam (Publication #02248); Guide to Medicare Preventive Services (Publication #10110); and Medicare Coverage of Diabetes Supplies and Services (Publication #11022). A complete listing of all beneficiary publications is available at http://www.medicare.gov/ on the Web. Select "Publications" under "Search Topics". Many publications are available in different languages and formats including: Braille, Spanish, Audiocassette, and Large Print. To order copies for your office, fax your request to (410) 786-1905, and include the name of a contact person, phone number, and mailing address (no P.O. boxes please).

12. Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS provider educational products and is designed to promote national consistency of Medicare provider information developed for CMS initiatives. The MLN products are available on the Medlearn Web page, which gives easy access to Web-based training courses, comprehensive training

guides, brochures, fact sheets, CD-ROMs, and videos, as well as educational Web guides, electronic listservs, and links to other important Medicare Program information. All educational products are available free of charge and can be ordered and/or downloaded from the Medlearn Web page. The Medlearn Web page is located at http://www.cms.hhs.gov/medlearn. As always, we welcome your comments and suggestions for Medicare educational products.

13. Medicare Physician Web Site

A Web page designed to meet the Medicare information needs of physicians is available on the CMS Web site at http://cms.hhs.gov/physicians/. The page includes links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics. A special feature link on the page is the Medicare Physician Fee Schedule Look-up, an application that allows the user to look up physician service information regarding fee schedule amounts and geographic practice cost indices for every carrier and locality. The Web page also includes links to National Correct Coding Initiative (NCCI) edits and to specific information on the Practicing Physicians Advisory Council (PPAC), the PRIT, Medicare payments, and the participating physician directory. The CMS continues to work on improving the Web page to make it as comprehensive and easy to navigate as possible. The CMS welcomes feedback on information to include and other suggestions for improvement.

We have added a new heading titled "Specialty Web Pages" to the main Physicians Web page. Under this heading we will be adding links to pages of special interest to specific physician groups. The first specialty page "Medicare Information for Anesthesiologists" is available at http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp. Check the "Specialty Web Pages" section for additional pages to be added during the year.

14. "Medlearn Matters…Information for Medicare Providers"

One of the best sources for the latest Medicare information is "Medlearn Matters…Information for Medicare Providers." These national articles, which are written in consultation with clinicians and billing experts, are designed to give providers and their staff easy-to-understand information related to new and recently-changed Medicare rules and policies and to focus on how these changes impact a provider's Medicare business functions. The articles also serve to enhance and support Medicare carrier and intermediary local provider education efforts by promoting the availability of nationally consistent educational materials. Medicare carriers and intermediaries publish Medlearn Matters articles in their bulletins and post them on their Web sites. There is also a searchable table on the Medlearn Matters Web page. The Web page that contains links to each article and its corresponding program instructions, if applicable. The Medlearn Matters Web page is located at http://www.cms.hhs.gov/medlearn/matters.

15. Medicare-Approved Drug Discount Cards and Transitional Assistance Web Page

The Medicare-Approved Drug Discount Cards and Transitional Assistance Web page contains information and a variety of educational products that have been designed to assist physicians, pharmacists, and other health care providers in understanding Medicare prescription drug provisions in the MMA. The Web page has links to helpful information about the MMA, State

Health Insurance Assistance Programs, and beneficiary materials, as well as links to a drug price comparison Internet tool and a Web-based training tool. Educational brochures, posters, and articles can be downloaded from the Medicare-Approved Drug Discount Cards and Transitional Assistance Program Web page located at http://www.cms.hhs.gov/medlearn/drugcard.asp. Physicians, pharmacists, and other health care professionals may display the Medicare-Approved Drug Discount poster at their offices to assist Medicare patients in finding out where to find information about the Medicare-approved drug discount card. The poster is available in both English and Spanish versions, and may be ordered free of charge from the Medlearn Web page located at http://www.cms.hhs.gov/medlearn.

16. Medicare Resident & New Physician Training Program

As the aging population continues to increase, it is more important than ever that the physicians who are providing care to our seniors have a good understanding of the workings of the Medicare program. Therefore, the CMS is pleased to report that the ***Medicare Resident & New Physician Training (MRNPT) Program Facilitator's Kit*** is now available from the Medlearn Web site Product Ordering System at www.cms.hhs.gov/medlearn. The ***Facilitator's Kit*** includes everything that is needed to conduct training sessions for finishing residents, new physicians, and other health care providers who are seeking Medicare information as it relates to physician services. New products in the ***Facilitator's Kit*** include a copy of our latest resident training video and a CD-ROM version of our newly developed Web-based training course that is based on the ***Medicare Resident & New Physician Guide*** publication. We have also significantly revised the Facilitator's Guide, which contains all the information and instructions needed to prepare for and conduct the MRNPT Program, so that it is a more user-friendly and concise product that can be utilized by Medicare contractors, regional offices, medical schools, teaching hospitals, and other provider education training partners.

17. Medicare Contractor Provider Satisfaction Survey (MCPSS)

Recognizing the important role that provider perceptions have of the CMS and the role that fee-for-service contractors play in representing the Medicare program to providers, the Agency is taking steps to obtain and evaluate provider satisfaction with services provided by our Medicare contractors. The survey will be pilot tested in 2005 with 7,000 providers of all types. If you are asked to participate in this survey, your timely comments will be very much appreciated!

18. Exhibit Program

The CMS continues to depend upon its Exhibit Program to help ensure that we provide enhanced customer service and satisfaction to our Medicare physician and provider community. Fiscal Year 2004 marked a significant increase in the number of CMS exhibits at national conferences -- 92 conferences in all. The Exhibit Program represents a unique opportunity for CMS central and regional office staff to have direct contact with physicians and providers to share timely and relevant information and to hear directly from you about the issues, concerns, and challenges you face in the Medicare program.

19. Listserv Messages

The CMS has a number of listservs for Medicare providers that are used to transmit up-to-the-minute information specific to the providers who have subscribed. (A listserv is an electronic mailing list service for those interested in receiving Medicare news.) Listservs have been established for physicians and DMEPOS-suppliers. To view the entire menu of available listservs and to subscribe to one or more listserv, view the link at http://www.cms.hhs.gov/mailinglists/ and follow the directions. Important notices and reminders will be automatically sent to your email address via the Internet.

20. Medicare Contractor Web Sites and Listservs

In addition to the CMS Web sites and listservs, each Medicare contractor has its own Web sites and listservs. Make sure to subscribe to the listservs that your contractor has available and visit the Web site regularly to stay up-to-date on Medicare changes. Links to all contractor Web sites can be found at http://www.cms.hhs.gov/medlearn/tollnums.asp.

21. The CMS Quarterly Provider Update

The CMS Quarterly Provider Update is an Internet-only document and is released quarterly (January, April, July, and October.) It provides a single source for you to turn to and will give you advance notice on instructions that affect you at least 90 days before they are implemented.

It is organized by provider type and contains the following information:

- Regulations and major policies currently under development during the quarter.
- Regulations and major policies completed or cancelled.
- New/revised manual instructions.

The CMS Quarterly Provider Update can be accessed from the Internet at: http://www.cms.hhs.gov/providerupdate/.

22. The CMS Manual System

As you may know, as of October 1, 2003, the CMS transitioned from a paper-based manual system to a Web-based system. This system is called the online CMS Manual System and is located at http://www.cms.hhs.gov/manuals/.

The online CMS Manual System is organized in six parts: Internet-Only Manuals (IOMs), Future IOM Updates, Program Transmittals, Crosswalks, Paper Based Manuals, and Program Memoranda. The IOM manuals themselves are organized by functional area (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity) as opposed to the old paper manuals, that were organized by audience. The functional orientation of the new manual has eliminated significant redundancy within the manuals, and has streamlined the updating process. It has also made information available sooner.

The CMS manual system is still evolving and we welcome any comments or suggestions on its improvement. Please send these comments or suggestions via our site Feedback form: http://www.cms.hhs.gov/feedback/.

23. Medicare Coverage Information

The Medicare Coverage Database, which is on the http://www.cms.hhs.gov/ Web site, includes the local medical review policies (LMRPs) and the National Coverage Determinations (NCDs). This database allows users to search across NCDs, LMRPs, and contractor articles/FAQs from a single point of entry. The database can be accessed by going to http://www.cms.hhs.gov/mcd/search.asp.

24. The CMS Publishes Nursing Home Quality Measures

The CMS provides quality data about nursing homes on their beneficiary Web site http://www.medicare.gov. The quality data enables beneficiaries, their caregivers, and families to choose a nursing home based on information relevant to both long-stay (chronic) and short stay (typically Medicare-covered). The measures represent the best available science and include a risk adjustment methodology. This quality data is one source of information for consumers to use in choosing a nursing home. We encourage consumers to review the other data on the nursing home site, which includes nurse staffing, health inspections and compliancy findings. Consumers should visit nursing homes in person before selection. Additionally, quality improvement organizations in each state are assisting nursing homes to use the data to implement quality improvement strategies. Users can search for nursing homes by State, county, city, zip or name. Proximity searches from 0-500 miles are also available when searches are made on city or zip code.

25. The CMS Publishes Home Health Quality Measures

The CMS launched Home Health Compare Nationally on its beneficiary Web site, http://www.medicare.gov/, in October 2003. Home Health Compare contains information about Medicare-certified home health agencies. Specific information includes the name, address and phone number of the agency; Medicare-covered services offered by the agency; the agency's initial date of Medicare certification; and type of ownership. Home health quality measures are available for all Medicare certified home health agencies in the nation.

26. Coming Soon – The CMS to Publish Hospital Quality Measures

The CMS will launch Hospital Compare nationally on its beneficiary Web site, http://www.medicare.gov/, in February 2005. Hospital Compare will contain information about Medicare-certified hospitals. Specific information will include the name, address, telephone number, and accreditation status. For hospitals that have submitted data for three clinical conditions; heart attack, heart failure, and pneumonia, quality measures will be available on the Medicare.gov site.

27. Online Participating Physician Directory

As part of the ongoing effort to provide Medicare beneficiaries with information to help them make health care choices, the CMS has a participating physician directory at www.medicare.gov, the CMS' beneficiary Web site. The directory can be accessed from the home page under the *Participating Physician Directory*. Initially, the directory contained only names, addresses, and specialties of Medicare participating physicians who agreed to accept assignment for all covered services. In May 2003, the Participating Physician Directory added several features including information about physicians, such as their medical school and year of graduation, any board certification in a medical specialty, gender, and hospitals at which the physician has admitting privileges. The directory, which is updated monthly, also includes the participating physician's office phone number and any foreign language capabilities. In the future, the directory will contain information on whether a physician is accepting new Medicare patients.

The information in the database comes from the Unique Physician Identification Number (UPIN) Registry. The directory is updated monthly. Corrections or changes to the information will be reflected on the Web site, the month after an update is made to the UPIN registry.

28. Medicare Advantage Private Fee For Service Plans

The Balanced Budget Act of 1997 allowed for a new type of Medicare Advantage (MA) plan, Private Fee For Service (PFFS). A MA PFFS plan may be designed without a provider network. In order to offer a PFFS plan without provider contracts, the PFFS organization must agree to pay all Medicare eligible providers the current Medicare allowable rates (including original Medicare deductibles and coinsurance) minus any plan specific enrollee cost sharing. This payment rate is mandated via specific regulation as well as the contract that the CMS holds with the PFFS organization. Further, depending on the PFFS plan design, providers may balance bill enrollees of PFFS plans. However, even if the plan design allows this balance billing, it is limited to an amount of 15 percent of the PFFS plan payment amount. Currently, there are no PFFS contracts that allow balance billing. Other than this balance billing amount (if included in the plan's design), providers may only bill Medicare beneficiaries for co-payments, deductibles or coinsurance which are described in the MA plan's terms and conditions of payment and the enrollee's Evidence of Coverage. All other bills must be sent to the PFFS organization. For additional information, including frequently asked questions, please visit the CMS web site at http://www.cms.hhs.gov/healthplans/pffs.

29. Changes to the Medicare Appeals Process

Effective October 1, 2004, all first level Medicare appeals will be called redeterminations. This will include those appeals now known as reviews and reconsiderations. In addition, contractors must complete all redeterminations within 60 days. These new timeframes will apply to redeterminations requested on or after October 1, 2004. You will be notified of the redetermination decision with the new Medicare Redetermination Notice (MRN). The new model letter was developed using feedback provided during extensive consumer testing with both providers and beneficiaries. The new notice provides information in a user-friendly manner that will be more consistent across Medicare contractors than current decision letters. There are

further important changes on the horizon for the Medicare appeals process, beginning in 2005. The major benefits will be more accurate and timely appeals decisions. The changes include:

- A uniform process for Medicare Part A and Part B appeals,
- New timeframes for appeal determinations,
- Expanded appeal rights for providers and suppliers, and
- The establishment of a new independent review entity, called a Qualified Independent Contractor (QIC), to perform reconsiderations of redetermination decisions.

30. The Voluntary Chronic Care Improvement Program (MMA Section 721)

The Chronic Care Improvement Program is an important component of the Medicare Modernization Act and demonstrates a commitment to improving and strengthening the traditional fee-for-service Medicare program. This program is the first large-scale chronic care improvement initiative under the Medicare FFS program. The CMS will select Chronic Care Improvement Organizations (CCIOs) that will offer self-care guidance and support to chronically ill beneficiaries. CCIOs will help beneficiaries manage their health, adhere to their physicians' plans of care, and assure that they seek or obtain medical care that they need to reduce their health risks.

- Initially, the programs will be focused on beneficiaries who have Congestive Heart Failure (CHF), Complex Diabetes, or Chronic Obstructive Pulmonary Disease (COPD) because these beneficiaries have heavy self-care burdens and high risks of experiencing poor clinical and financial outcomes.

- The new programs are NOT single-disease focused. They will be designed to help participants manage all their health problems.

- Participation will be entirely voluntary. Eligible beneficiaries do not have to change plans or providers or pay extra to participate.

For additional information on this initiative, please go to
www.cms.hhs.gov/medicarereform/ccip