



The Pulse of CMS

“A quarterly regional publication for health care professionals”
Serving Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

A Healthier US Starts Here Campaign Launched

The U.S. Department of Health and Human Services (HHS) and CMS have launched A Healthier US Starts Here campaign, an initiative focused on motivating seniors and others with Medicare to make the most of Medicare's prevention services and maintaining healthy lifestyles. Throughout 2007 there will be events and programs designed to promote conversations between people with Medicare, families, caregivers, health professionals, and community organizations about prevention services that Medicare covers to help keep beneficiaries healthy.

The message from CMS to people with Medicare is clear: "Talk to your doctor to see what services are right for you." CMS anticipates that clinicians will be hearing from their patients about Medicare-covered prevention benefits and we wanted to provide you with information about correct coding for these services. A [copy of the brochure](#) that offers a checklist of the Medicare-covered preventive services can be found on the CMS website.

CMS has also developed [a quick reference chart](#) that provides the codes for your office staff to use in billing for preventive services. You can also find a copy of a [comprehensive toolkit](#) that includes information for patients. You can also get information about coverage, coding and billing of Medicare-covered preventive services from the [Medicare Learning Network Preventive Services Educational Products web page](#).

The prevention initiative will also encourage people to use the CMS website, www.mymedicare.gov (see article on page 2). People with Medicare can also get this same information by calling 1-800-MEDICARE. We hope that you will work with us to help people make the most of their Medicare. By educating your patients about the Medicare covered preventive services that are right for them, we can make sure that a healthier US starts here!

Current Medicare Preventive Benefits...

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

Inside this Issue...

Using Best Available Data for Dual Eligibles	2
Grants for Nursing Home Alternatives.....	2
Using the Internet for Health Management.....	2
New MLN Articles & Training	3
NPI Data Dissemination.....	3
PQRI Reporting Started	3
Clearinghouse Issues.....	4
Survey & Cert of Transplant Programs.....	4

Providers Continue to Show Satisfaction with Medicare Contractors

Most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS), distributed by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction.

The MCPSS was sent earlier this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country.

The full results of the 2007 survey are now available at the [MCPSS website](#).

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Using "Best Data Available" for Dual Eligibles

CMS instructed Part D plans that they are required to use the "best available data" to make changes to their systems when they have knowledge that a dual eligible beneficiary's cost sharing level is not correct. Dual eligible beneficiaries are those individuals that qualify for both Medicare and Medicaid benefits.

Part D plans have flexibility to develop their own procedures for determining whether best available information is sufficient to change or update their systems to reflect appropriate cost sharing levels for dual eligibles. For example, a Part D plan may rely on the beneficiary showing the contracted pharmacy a current Medicaid card or information provided by a state Medicaid office as proof of low-income subsidy status. Since the Part D plan will not know the exact subsidy level for the dual eligible beneficiary, it should default the enrollee to a \$2/\$5 benefit package.

For full benefit dual eligibles who are residents of long term care (LTC) facilities, a plan may develop procedures that rely on attestations from LTC pharmacy and facility personnel that certain residents who are enrollees of the plan are Medicaid eligible, have been or are expected to be residents of the facility for a full calendar month, and are under a Medicaid-covered stay. For LTC facility residents, Part D plans should rely on information that clearly indicates the elements necessary to confirm Medicaid eligibility and LTC facility admission dates for purposes of establishing a full calendar month of LTC facility residency.

As part of their procedures, Part D plans should keep appropriate records in order to reconcile low-income subsidy payments with CMS after the end of the contract year.

Provider Outreach Staff:

Melissa Scarborough
Phone: (214) 767-4407

E-mail your questions and comments to us at: RODALINQUIRY@cms.hhs.gov

CMS Awards Grants for Alternatives to Nursing Home Care

Thirteen states and the District of Columbia will get more than \$547 million in grants over five years to build Medicaid long-term care programs that will help keep people at home and out of institutions. These awards are the second round of grants that will total \$1.75 billion over five years to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community-based services.

This "Money Follows the Person" initiative was included in the Deficit Reduction Act of 2005 (DRA), currently being implemented by CMS. It is a component of the administration's New Freedom Initiative, a nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses. States expect to be able to move more than 14,000 people into community settings using these grant awards.

States receiving grants today will design programs with three major objectives:

1. Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the settings of their choice;

2. Increase the ability of the state Medicaid program to assure continued provision of home and community based long-term care services to eligible individuals who choose to move from an institutional to a community setting; and
3. Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

States receiving grant funds will qualify for a higher percentage of federal matching dollars to help cover the costs of moving people out of nursing homes and into community settings. The higher matching rate will be paid for one year after an individual moves out of an institution and into the community. The state must continue to provide community services after that period as long as the person needs community services and is Medicaid eligible.

For more details about the New Freedom Initiative, of which this demonstration is part, visit the [New Freedom Initiative page](#) of the CMS web site.

Using the Internet to Help Beneficiaries Manage Their Own Health Care

The Centers for Medicare & Medicaid Services (CMS) announced a new project expanding its efforts to encourage Medicare beneficiaries to take advantage of Internet-based tools to track their health care services and provide them with other resources to better communicate with their providers.

This pilot program will enable certain beneficiaries to access and use a Personal Health Record (PHR) provided through participating health plans, and accessible through www.mymedicare.gov. In general, a PHR is a collection of information about an individual's health or health care services, such as medical conditions, hospitalizations, doctor visits and medications. The data that will be made available to the beneficiaries include registration information such as name, address, and policy number as well as lists of their medications and medical conditions.

medical conditions to help them manage their own health care. The beneficiary is in charge of his or her own PHR and will control who is able to see the information it contains. Sharing this information with healthcare providers from the PHR will be entirely up to the beneficiary. The goals of the pilot, which is to run for 18 months, are to:

1. Determine the features that are most attractive to Medicare beneficiaries;
2. Identify the minimum content and functionality for the PHR tools; and
3. Assess the best methods for outreach and education to encourage adoption and ongoing use.

The ability to access a fuller, more comprehensive PHR from health plans, through the Mymedicare.gov site, is an added benefit to its current services.

The PHR tools will allow the beneficiary to look up information about their own medications and

Important MLN Article Available on NPI

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



National Provider Identifier Data Dissemination Info

The NPI Registry, a query-only database, will be operational on August 1, 2007. The NPI Registry will operate in a real-time environment. Data that is able to be disclosed under the Freedom of Information Act (FOIA) for newly enumerated providers, as well as updates and changes to enumerated providers' data, will be available in the NPI Registry as that information is applied to the National Plan & Provider Enumeration System (NPPES).

The NPI Registry will enable a user to query by, for example, NPI or provider name, and will return a list of all NPPES records that meet the query specifications. The user selects from that list the NPPES records he/she wants to see. The NPI

Registry will then display the FOIA-disclosable data for those records.

About a week later, CMS will make available a file for downloading that will contain the FOIA-disclosable NPPES data of enumerated health care providers. Technical expertise will be required to download that file and to import that data into a relational database or to otherwise manipulate the data.

CMS will be furnishing more information about data dissemination, including a "Read Me" file, Header File, and Code Value document for the downloadable file, and will make that information available on the [CMS NPI web page](#).

New MLN Training Courses

- The *Diagnosis Coding Using the ICD-9-CM* web-based training course provides an overview of ICD-9-CM coding. This course provides an understanding of ICD-9-CM definitions and coding guidelines; components and characteristics and coding conventions; the use of tables within the ICD-9-CM volumes and how to better understand difficult coding situations. This course is now available with continuing education credits and can be accessed through the Web-based training modules link at www.cms.hhs.gov/MLNProducts under the "Related Links Inside CMS" section.
- The *CMS Form 1500 (08-05)* web-based training course provides information that will allow you to file claims accurately and reduce your chances of receiving "unprocessible claim" rejections. In this course, the CMS Form 1500 (08/05) is used to teach the learner about claim requirements for the paper form. This course is now available with continuing education credits and can be accessed through the Web-based training modules link at www.cms.hhs.gov/MLNProducts under the "Related Links Inside CMS" section.

Physician Quality Reporting Initiative Is Underway...Start Reporting Now!!

The 2007 Medicare Physician Quality Reporting Initiative (PQRI) began July 1 and will end December 31, 2007. It is not too late to begin participating in the program. However, calculation of a provider's successful reporting will include all eligible claims submitted to CMS beginning July 1.

Professionals that report successfully are eligible for a 1.5 percent bonus payment, subject to a cap. The potential 1.5% bonus is based on total allowed charges paid under the Physician Fee Schedule. This includes the patient portion, the technical component, anesthesia services, drug administration, and Railroad Retirement Board (RRB) charges. The bonus payment excludes laboratory services, drugs, HPSA bonuses, and denied line items.

Please note that some clearinghouses are stripping the National Provider Identifier (NPI) prior to submission of the claim to Medicare. This will adversely affect eligible professionals in that these claims will not count toward PQRI participation. CMS urges eligible professionals that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the eligible professional determines that their

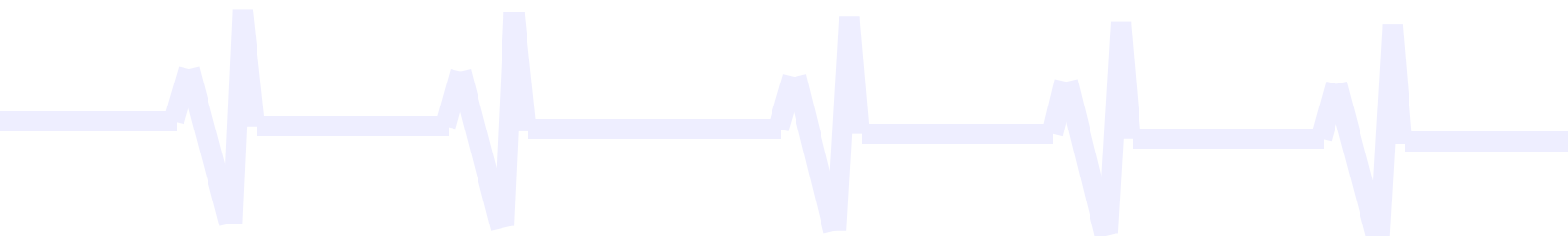
clearinghouse is stripping NPIs from the claim, the eligible professional may want to consider other billing options.

A recent Special Edition MLN Matters article contains important information for Medicare providers and suppliers, including how to use the NPI correctly on Part A and Part B claims. You can view this article by visiting [the CMS website](#).

There is no need to register, just begin reporting through your claims process. In order to participate, you must be an enrolled Medicare provider, but need not have signed a Medicare participation agreement. You need to use individual National Provider Identifier (NPI) on your claims form.

The final measure descriptions for 2007 with detailed specifications, a Coding Handbook, frequently asked questions, and data collection worksheets are now posted on the [PQRI section of the CMS website](#).

The final measures for the 2008 PQRI program will be published in the Federal Register by August 15, 2007.



Potential Issues with Clearinghouses Practices

Some clearinghouses are stripping the National Provider Identifier (NPI) off the claim prior to its submission to Medicare. This could adversely affect Medicare providers in two ways. First, providers may be under the false impression that their claims are being successfully submitted to Medicare, through their clearinghouse, using an NPI. Second, without the NPI, these claims will not count toward PQRI participation for eligible professionals. Stripping of NPIs may also be occurring even though the NPI appears on remittance advice because some clearinghouses are adding the NPI to the remittance prior to sending to the provider.

CMS urges Medicare providers that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the provider determines that their clearinghouse is stripping NPIs from the claim, the provider may wish to consider other billing options.

CMS has also become aware that some clearinghouses are not forwarding to providers NPI informational claim error messages being sent by Medicare carriers. While claims are being paid today based on the legacy identifier, these messages are designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers. Providers who use clearinghouses should make sure they are in fact receiving NPI informational claim error messages so that issues can be addressed timely.

Dallas Regional Office:

1301 Young Street
Room 833
Dallas, TX 75202

Phone: (214) 767-6423

Fax: (214) 767-6400

Email: RODALINQUIRY@cms.hhs.gov

DHHS Issues Regs for Survey and Certification of Transplant Programs

On March 30, 2007, the Department of Health and Human Services (DHHS) issued regulations authorizing the survey and certification of transplant programs. All hospital transplant programs, approved for Medicare participation as of June 28, 2007 (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. This request must be submitted to CMS by December 26, 2007 (180 days from the effective date of the regulation).

Requests may be mailed or faxed to CMS at the address/fax number below:

Centers for Medicare and Medicaid Services
Attention: Sherry Clark
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

Faxed To:
(410) 786-0194
Attention: Sherry Clark

There is no official application form. Each approved program should prepare a letter to CMS formally requesting Medicare approval for their program(s) under the new *Hospital Conditions of*

Participation: Requirements for Approval and Re-approval of Transplant Centers to Perform Organ Transplants. A hospital may submit one request for approval of all their transplant programs within one letter. However, the approval request must include all the essential information about each program. Please visit the [CMS Survey and Certification website](#) for the specific information that must be included in an approval request.

CMS will notify each applicant upon receipt of the approval request, will review the information submitted, and will schedule an on-site review of the program(s). If a program does not submit a request for approval under the new Conditions of Participation by December 28, 2007, CMS will conclude that the program no longer desires Medicare participation and will begin the process to withdraw Medicare approval.

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.

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region VI provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS or CMS. HHS or CMS is not responsible for the contents of any "off-site" resource identified.

