



The Pulse of CMS

“A quarterly regional publication for health care professionals”
Serving Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.

CMS ANNOUNCES GEOGRAPHIC AREAS AND PRODUCTS FOR 2ND ROUND OF DMEPOS COMPETITIVE BIDDING PROJECT. SEE STORY ON PAGE 2.

NPI Numbers Now Mandatory on All Part B Claims

Effective March 1, 2008, all 837P and CMS-1500 claims must have a National Provider Identifier (NPI) or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject. This is the second key implementation date for NPI, as institutional claims were required to have the same information in order to be paid as of January 1, 2008. This is in preparation for the May 23, 2008 deadline when all claims must have NPIs only in order to be paid. The latest information can be found on the [NPI page of the CMS website](#).

As always, testing is of the utmost importance. For providers who have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number).

If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. If the claim is

processed and you are paid, continue to increase the volume of claims sent with only your NPI. There is the possibility that the claims could reject. If this happens, then go into your National Plan and Provider Enumeration System (NPPES) record and validate that the information you are sending on the claim is the same information as in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims three to four days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. It is important to have a copy of your NPPES record available.

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/NationalProviderStand 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.

CMS Releases QIO 9th Statement of Work

On January 22, 2008, CMS released the 9th Statement of Work (SOW) for Medicare's 53 Quality Improvement Organizations (QIOs). The 9th SOW is focused on improving the quality and safety of services for beneficiaries and provides CMS with additional tools to link the work completed by the QIOs to measurable outcomes that are reviewed and measured during the entire length of the three-year contract.

Responding to concerns raised by the Institute of Medicine, the Government Accountability Office and Congress, CMS is focusing additional efforts and resources to ensure that the QIOs provide Medicare beneficiaries with the highest value in their efforts to improve the quality of care among health care providers. As part of the contract requirements, QIOs will focus their improvement efforts on protecting beneficiaries, care transitions, patient safety and prevention.

Each program has measurable criteria, close monitoring and performance improvement plans to gauge each QIOs' performance under the contract. QIOs will be required to work with local nursing homes and hospitals to help them improve specific quality measurements – 85 percent of those facilities will be identified by CMS and the remaining 15 percent will be selected by the QIOs. CMS selected the facilities that are targeted for improvement during the QIO 9th SOW by reviewing the recent publicly reported Quality Measure results, which are found on the “Hospital Compare” and “Nursing Home Compare” websites at www.medicare.gov.

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Getting the Word Out: Cardiovascular Screenings

CMS needs your help getting the word out about the cardiovascular screening benefit covered by Medicare. Talk with your patients about their risk factors for cardiovascular disease and how they can help lessen their risk through lifestyle modifications such as diet, physical activity, better control of cholesterol, and smoking cessation or if necessary with medication. Encourage your Medicare patients not previously diagnosed with cardiovascular disease to take full advantage of the cardiovascular screening blood tests covered by Medicare. It could save their lives!



CMS Identifies Improper Payments in Three States

CMS has announced that \$371.5 million in improper Medicare payments has been collected from or repaid to health care providers and suppliers as part of a demonstration program using recovery audit contractors (RACs) in California, Florida and New York in 2007. Nearly \$440 million has been collected since the program began in 2005.

"The RAC demonstration program has proven to be successful in returning overpayments to the Trust Fund and identifying ways to prevent future improper payments," Acting CMS Administrator Kerry Weems said.

The RAC demonstration program, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is designed to find and correct improper Medicare payments paid to health care providers participating in fee-for-service Medicare. Medicare processes more than 1.2 billion Medicare claims annually, submitted by more than one million health care providers, including hospitals, skilled nursing facilities, physicians and medical equipment suppliers. Errors in claims submitted by these health care providers for services provided to Medicare beneficiaries can account for billions of dollars in improper payments each year.

Approximately 96 percent of the improper payments identified by the RACs in 2007 were overpayments collected from health care providers; the remaining 4 percent were underpayments repaid to health care providers. The demonstration program began in California, Florida and New York in 2005 and expanded into Massachusetts, South Carolina, and Arizona in 2007. The first three states are those states with the largest number of Medicare claims.

Most of the improper payments that the RACs identified occurred when health care providers submitted claims that did not comply with Medicare's coverage or coding rules. More than 85 percent of the overpayments collected by RACs and almost all underpayments refunded by the RACs were from claims submitted by inpatient hospitals.

The RAC demonstration was authorized in the MMA by Congress and was required to be a permanent part of Medicare in the Tax Relief and Healthcare Act of 2006. CMS will enter into new contracts as the national program is implemented before January 1, 2010.

For more information on the RAC program and to view the FY 2007 Status Document, visit: <http://www.cms.hhs.gov/RAC>

Second Round of DMEPOS Competitive Bidding Parameters Announced

On January 8, 2008, CMS announced the Metropolitan Statistical Areas (MSAs) and product categories for the second round of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) new competitive bidding program. The program is designed to improve the effectiveness of Medicare's DMEPOS payments, reduce beneficiary out-of-pocket costs, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services by requiring suppliers to be accredited by a Medicare-recognized accreditation organization.

All suppliers must meet quality standards and be accredited by a CMS-recognized accreditation organization in order to obtain a contract under the Medicare DMEPOS competitive bidding program. Due to the size of this expansion and our experiences from round 1 of the program, we strongly encourage suppliers to seek accreditation as soon as possible to avoid any potential difficulties that would affect their ability to bid. Information on accreditation requirements and a list of CMS-recognized accreditation organizations can be found on the [CMS website](#).

The MSAs in Region 3 included are:

- Scranton-Wilkes Barre, PA
- Allentown-Bethlehem-Easton, PA-NJ
- Youngstown-Warren-Boardman, OH-PA
- Richmond, VA
- Virginia-Beach-Norfolk-Newport News, VA-NC
- Huntington-Ashland, WV-KY-OH

The program will be expanded into additional areas after 2009.

Guided Pathways to Medicare Resources for Medicare Fee-For-Service Providers Available

CMS is pleased to announce the availability of the latest *Medicare Learning Network* provider education product entitled, "Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals." "Guided Pathways" has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare program, as well as for those professionals looking for easy access to the many resources on the CMS website.

The second round of the Medicare DMEPOS Competitive Bidding program will include 8 of the top DMEPOS product categories. These product categories were selected based on criteria outlined in the regulation. The following are the product categories for round two:

- 1) Oxygen Supplies and Equipment
- 2) Standard Power Wheelchairs, Scooters, and Related Accessories
- 3) Complex Rehabilitative Power Wheelchairs and Related Accessories
- 4) Enteral Nutrients, Equipment, and Supplies
- 5) Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices (RADs), and Related Supplies and Accessories
- 6) Hospital Beds and Related Accessories
- 7) Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories
- 8) Walkers and Related Accessories

A listing of the items contained in each product category will be announced in the next few months.

Over the next few months, announcements and updates containing important information about the second round of the Medicare DMEPOS Competitive Bidding Program will be provided on the [CMS website](#) and on the Competitive Bidding Implementation Contractor, or [CBIC website](#).

Using a "road trip" motif, the guide leads users through nine broad sections of information covering the Medicare program, with links to further pertinent information. The guide also provides links to other government resources pertaining to Medicare FFS items. "Guided Pathways" can be accessed on the [Medicare Learning Network website](#).

Focus on Prevention: Diabetes and Renal Disease Benefits

CMS wants to focus on two of the many preventive services that are now available to all Medicare beneficiaries: Diabetes Self-Management and Medical Nutrition Therapy.

Diabetes Self-Management Training

Medicare approves certain diabetes self-management training services to help beneficiaries successfully manage their disease. A beneficiary can receive diabetes self-management training services if he or she is at risk for complications from diabetes, has been recently diagnosed with diabetes, or has diabetes and is now eligible for Medicare. Beneficiaries pay 20 percent of the Medicare-approved amount after the yearly Part B deductible for diabetes self-management training services. The physician managing the beneficiary's diabetes must certify that diabetes self-management training services are needed under a comprehensive plan of care.

Medical Nutrition Therapy

Medical nutrition therapy services are also covered for people with diabetes or renal disease when referred by a doctor. These services can be given by a registered dietitian or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help beneficiaries manage their diabetes or kidney disease.

Medicare covers three hours of one-on-one counseling services the first year, and two hours each year after that. A doctor must prescribe these services and renew referrals yearly if continuing treatment is needed into another calendar year.

Beneficiaries who have diabetes or renal disease are eligible with a doctor's referral up to three years after a kidney transplant. Beneficiaries pay 20 percent of the Medicare-approved amount after the yearly Part B deductible.

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Electronic Health Records Demo Kicks Off in Richmond, VA

On February 7, 2008, at the state Capitol building in Richmond, VA, HHS Secretary Mike Leavitt met with stakeholders from throughout the Richmond area to encourage community leaders to join together and apply for a new CMS demonstration project that links physicians' use of interoperable electronic health records to improve patient care with Medicare incentive payments. The project, which is open to small- and medium-sized primary-care physician practices, is expected to reduce medical errors and improve the quality of care for an estimated 3.6 million Americans.

Secretary Leavitt and other senior HHS officials met directly with patients, providers, health plans, and local and business leaders in Richmond and communities across America to discuss this new demonstration project.

"Communities like Richmond have a tremendous opportunity to help transform health care delivery starting at the local level," Secretary Leavitt said. "Broad adoption of interoperable electronic health records has the potential not only to improve the quality of care provided, but also to change the way medicine is practiced and delivered. By implementing this demonstration project in a dozen health markets across the country, we'll help move this nation toward a system that delivers better quality health care at lower cost for more Americans."

Over a five-year period, financial incentives will be provided to as many as 1,200 physician practices

that use certified electronic health records (EHR) to improve quality as measured by their performance on specific clinical quality measures. In addition to the incentive payments, bonus payments may be awarded based on a standardized survey measuring the number of EHR functionalities a physician group has incorporated into its practice.

An application period is now open for communities interested in becoming one of the pilot program's 12 sites. The Centers for Medicare & Medicaid Services (CMS) will focus on locations where the demonstration may enhance existing or planned private sector projects related to health information technology and quality reporting initiatives.

Eligible communities will include those that:

- Can demonstrate active community stakeholder collaboration, which includes fostering private sector support;
- Are geographically large enough to have a sufficient number of physician practices; and
- Are not already participating in a CMS demonstration project that conflicts with the EHR project.

CMS expects that the demonstration will start with four communities in 2008, with the remainder beginning in 2009.

For more information about the EHR demonstration project, visit the [CMS website](#).

Tamper-Resistant Prescription Pads Required for Medicaid Soon

Beginning April 1, 2008, all written prescriptions for Medicaid recipients must be on paper with at least one tamper-resistant feature as outlined by CMS and defined by your State. Beginning October 1, 2008 these same prescriptions must be on paper that meets all three baseline characteristics of tamper-resistant pads. CMS has outlined the three baseline characteristics as those that: 1) prevent unauthorized copying of a completed or blank prescription form; 2) prevent the erasure or modification of information written on the prescription by the prescriber; or 3) prevent the use of counterfeit prescription forms.

order for a prescription to be considered tamper-resistant in that State. Therefore, CMS recommends reviewing your State's website for guidance on acceptable tamper-resistant features. Additional information on CMS' requirements can be found on the [CMS website](#).

Please note that electronic prescriptions, faxed prescriptions and prescriptions sent over the telephone are exempt from this requirement.

Failure to comply with this requirement could result in a withholding of Medicaid reimbursement.

States are responsible for defining specific features that meet the baseline characteristics in

Artificial Heart Devices Coverage

The Centers for Medicare & Medicaid Services (CMS) has proposed coverage with evidence development of artificial heart devices. CMS proposes to cover artificial heart devices in Medicare beneficiaries who are enrolled in Food and Drug Administration (FDA)-approved studies.

Because patients in need of artificial hearts are extremely sick and at imminent risk of death, the device can be used to enable a patient to live until a donor heart becomes available for transplant or, for a non-transplant patient, to extend his or her life. Since the device requires a portion of the patient's own heart be removed, an artificial heart patient must be supported by his or her device through the end of life or until heart transplantation.

The use of artificial heart technology has not been available to Medicare beneficiaries due to a 1986 non-coverage policy. Since the 1986 policy, two artificial heart device manufacturers have run clinical trials studying the safety and health outcomes of using their devices in these very sick patients. CMS believes there is now sufficient scientific evidence on the use of artificial hearts to allow coverage of these devices for beneficiaries in the carefully controlled clinical environment of an FDA-approved study. Providing coverage with evidence development allows CMS to provide faster and more effective coverage with more informed clinical decision making.

CMS plans to issue a final national coverage determination in early May 2008. CMS invites public comments on its proposed decision, which is available on the [CMS website](#).

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2008 Physician Quality Reporting Initiative Now Underway

It is not too late to begin participating in CMS Physician Quality Reporting Initiative (PQRI) for 2008. There are 119 measures listed for the 2008 PQRI program, including structural measures related to electronic health records and e-prescribing. The measures address various aspects of patient care such as prevention, chronic care management, acute episodes of care management, procedurally related care, resource utilization and care coordination.

The PQRI program is a claims-based reporting program, so there is no need to register. The reporting process requires the use of CPT Category II codes (or temporary G-codes where CPT Category II codes are not yet available) for reporting quality data. Quality codes must be reported on the same claims as the payment codes.

The bonus payment of 1.5 percent to an eligible professional who successfully reports remains the same for the 2008 PQRI program, but the reporting period for 2008 covers a 12 month period beginning January 1 through December 31, 2008. The bonus calculation is based on total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule. However, for the 2008 PQRI, there

is no national or individual cap that would reduce an individual's earned incentive below the 1.5 percent of their allowable charges for the reporting period.

Successful reporting is determined by the following criteria:

- If four or more measures apply, at least three measures must be reported for at least 80 percent of the cases in which the measure was reportable.
- If there are no more than three measures that apply to the provider's practice, each measure must be reported for at least 80 percent of the cases in which a measure was reportable.
- For providers who report less than three applicable measures, the reported measures must be reported in at least 80 percent of cases in which a measure was reportable.

A [PQRI Tip Sheet](#) can be accessed at the PQRI website. [The 2008 Coding for Quality handbook](#) can also be accessed on the PQRI website. The site contains FAQs for 2008 and coding worksheets, which can be customized to practice processes.

This just in...

The Centers for Medicare and Medicaid Services is now accepting quality measure suggestions for possible inclusion in the proposed set of quality measures to be published in the 2009 Medicare Physician Fee Schedule Proposed Rule for the PQRI.

For more information on this opportunity to suggest measures for consideration for 2009,

Suggest 2009 PQRI Measures

please go to the [PQRI website](#) and select the Measures/Codes tab on the left side of the page. Next, scroll down to the Downloads section and select "Notice of 2009 Measure Suggestions."

Information Disclaimer:

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

Links to Other Resources:

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