

**MOA MEMBERS  
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR  
JULY 7, 2008**

**A MEDICARE UPDATE FROM CMS**

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**1. Claims Paid Under the Medicare Physician Fee Schedule**

To the extent possible, the Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other Fee-For-Service (FFS) providers of services paid under the Medicare physician fee schedule, beginning July 1. In this regard, CMS has instructed its contractors to hold these claims for the first 10 business days of July, for dates of service in July. This should have minimum impact on provider cash flow because, under current law, electronic claims are not paid any sooner than 14 days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before June 30 will be processed and paid under normal procedures.

After 10 business days, contractors will begin releasing claims into processing under the fee schedule which implements current law. This, of course, could result in claims being processed with the negative 10.6 percent update. If a new law is enacted which changes the negative 10.6 percent update, retroactive to July 1, CMS is prepared to automatically reprocess most of those claims which have already been processed.

Under the Medicare statute, Medicare pays the lower of submitted charges and the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1-June 30, 2008, fee schedule will be automatically reprocessed if Congress retroactively reinstates the update that was in effect for that time period. Any lesser amount will likely require providers to re-submit a revised claim.

To the extent possible, providers may hold claims in-house until it becomes clearer as to whether new legislation will be enacted or until cash flow becomes problematic. This will reduce the need for providers

to reconcile two payments (i.e., the initial claim and the reprocessed claim), and it will simplify provider billings of beneficiary coinsurance and payment calculations for payers which are secondary to Medicare.

In addition, be on the alert for more information about other legislative provisions which may affect Medicare FFS providers.

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## **2. Questions and Answers on Announced 10 Day Hold**

The Questions and Answers below apply to the recent decision by the Centers for Medicare & Medicare Services to hold for up to 10 business days claims paid under the Medicare physician fee schedule (MPFS) that contain July 2008 dates of service.

Q1. Will claims containing services paid under the MPFS be held that contain both June and July dates of service?

A1. Yes, your local contractor will hold the entire claim for 10 business days.

Q2. Will claims be held that contain both services paid under the MPFS and services paid under a separate fee schedule?

A2. Yes, claims that contain both services paid and not paid under the MPFS will be held. For example, a claim with a July date containing an Evaluation and Management code and a drug code would be held.

Q3. Does the holding of claims paid under the MPFS also include anesthesia and purchased diagnostic services?

A3. Yes, contractors will hold all claims with dates of service July 1, 2008, and after that contain services paid under the MPFS, including anesthesia and purchased diagnostic services.

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## **3. 2008 Physician Quality Reporting Initiative (PQRI) ~ National Provider Call to be held on July 9th**

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host the fifth in a series of national provider conference calls on the 2008 Physician Quality Reporting Initiative (PQRI). This toll-free call will take place from 3:30 p.m. – 5:00 p.m., EDT, on Wednesday, July 9, 2008.

This call will provide information on accessing your 2007 PQRI Feedback Report for those of you who participated in 2007, an overview of the 2008 PQRI participation options, and a question and answer session.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) which was enacted on December 29, 2007, requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. It also requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting quality measures data through registries.

In 2008, eligible professionals may earn an incentive payment of 1.5 percent of their total allowed charges for Physician Fee Service covered professional services furnished during the respective alternative reporting periods based on data submitted via these mechanisms. While TRHCA established a cap on incentive payments for 2007, based on an average per measure payment amount, there is no cap on incentive payments under MMSEA for 2008 and 2009.

These provisions provide increased opportunities for eligible professionals to report PQRI quality measures and the possibility to earn incentive payments for satisfactory reporting.

A PowerPoint slide presentation will be posted to the PQRI webpage at, [http://www.cms.hhs.gov/PQRI/02\\_CMSSponsoredCalls.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/02_CMSSponsoredCalls.asp#TopOfPage), on the CMS website for you to download prior to the call so that you can follow along with the presenters, Dr. Michael Rapp, Dr. Daniel Green and Rachel Nelson.

Following the presentation, callers will have an opportunity to ask questions of CMS subject matter experts.

Conference call details:

Date: July 9, 2008  
Conference Title: 2008 Physician Quality Reporting Initiative National Provider Call  
Time: 3:30-5:00 EDT

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 3:30 p.m. EDT on July 8, 2008, 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/070908>
2. Fill in all required data.
3. Verify your time zone is displayed correctly 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 will be 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. EDT 7/9/2008 until 11:59 p.m. EDT 7/16/2008. The call in data for the replay is (800) 642-1687 and the passcode is 52755102.

If you require services for the hearing impaired please send an email to [Medicare.TTT@PalmettoGBA.com](mailto:Medicare.TTT@PalmettoGBA.com).

#### **4. The Medicare DMEPOS Competitive Bidding Program is here!**

##### **Supplier Directory Locator Tool Now Available!**

As of Tuesday, July 1, 2008 the Supplier Directory on [www.medicare.gov](http://www.medicare.gov) has been updated to reflect the start of the DMEPOS Competitive Bidding program in certain areas of the country.

Users can begin their search on the Supplier Directory by entering their zip code. Product categories in that zip code that are competitive bid are identified, and special messaging will let users know if they have chosen an applicable product in a Competitive Bid Area (CBA) and why that is important to know. Search results for CBAs are organized by city of the zip code that was entered, and then by state. Users can sort by Supplier Name, and whether or not the supplier is participating. The address and phone number of the supplier is available.

Users are encouraged to check the site frequently as CMS will be making regular updates during the start of this program.

##### **Clarification of Common Carrier and Local Storefront Suppliers Under the CMS DMEPOS Competitive Bidding Program**

Common carrier, in its basic meaning, includes individuals or companies that transport goods or cargo (e.g., diabetic testing supplies) for compensation. This means that suppliers that pay a common carrier such as the U.S. Postal Service, Federal Express, United Parcel Service, or other shipping or courier service companies to transport diabetic testing supplies to Medicare beneficiaries' homes must be mail order contract suppliers under the DMEPOS Competitive Bidding Program, regardless of any contract arrangements suppliers may have with common carriers to deliver these items.

Diabetic supplies delivered by a common carrier to a Medicare beneficiary's home in a competitive bidding area must be furnished by a mail order contract supplier in order for Medicare to make payment unless the supplies are delivered by a local storefront using its own vehicles and W2 employees. This local storefront supplier must have its own local storefront that services the competitive bidding area, have its own location-specific National Supplier Clearinghouse (NSC) number for that storefront, bill for the diabetic supplies using that NSC number, and meet all of Medicare's supplier standards. It must also offer beneficiaries the choice of either obtaining the diabetic supplies from the supplier's storefront or having the items home delivered by the local storefront supplier using its own vehicles and W2 employees.

**Reminder: Enteral Nutrition is Not a “Grandfathered” Competitively Bid Item**

Under the DMEPOS Competitive Bidding Program, enteral nutrition must be furnished by a contract supplier and cannot be provided by a non-contract grandfathered supplier. To ensure that there is no gap in service, this is important information for providers who order enteral nutrition for Medicare beneficiaries who permanently reside in or are visiting a CBA.

**Educational Products: New SNF/NF Specialty Supplier Tip Sheet!**

Within the next day, CMS will post a new tip sheet on SNF/NF Specialty Suppliers under the DMEPOS Competitive Bidding Program.

Below is a complete listing of provider Tip Sheets that can be accessed from our dedicated web page:

- Tip Sheet for Skilled Nursing Facilities and Nursing Facilities: Specialty Contract Suppliers
- Tip Sheet for Referral Agents
- Tip Sheet for “Grandfathered” Suppliers
- Tip Sheet for Mail-Order Diabetic Testing Suppliers
- Tip Sheet for Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers
- Tip Sheet for Non-Contract Suppliers

Go to [www.cms.hhs.gov/DMEPOSCompetitiveBid](http://www.cms.hhs.gov/DMEPOSCompetitiveBid) to access all the latest information on the new program. Just click on the “Provider Educational Products and Resources” tab on the left then scroll down to the “Downloads” section for all *MLN Matters* articles, Tip Sheets, and links to beneficiary educational products as well.

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**5. DMEPOS Competitive Bidding national provider call for referral agents and non contract suppliers - July 8, 2008**

CMS will host a national audio call to address additional questions on the DMEPOS Competitive Bidding Program, which was implemented today, July 1, 2008. The call will be held on July 8, 2008 from 2:30 to 4:00 PM EDT. This call will not address contract supplier issues, but will instead focus on questions from non-contract suppliers and referral agents (Medicare providers who order or refer DMEPOS in the 10 CBAs).

Please note -- Participants will be able to submit questions through the online registration system at the time of sign up for the call. Registration details follow.

Conference call details:

Date: July 8, 2008  
Conference Title: DMEPOS Competitive Bidding Program  
Time: 2:30-4:00 p.m. EDT

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 2:30 p.m. EDT on July 7, 2008, 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/070808>
2. Fill in all required data.
3. Verify your time zone is displayed correctly 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 will be unable to attend, a replay option will be available shortly following the end of the call. This replay will be accessible from 4:30 p.m. EDT 7/8/2008 until 11:59 p.m. EDT 7/15/2008. The call in data for the replay is (800) 642-1687 and the passcode is 53825755.

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## 6. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding News!

CMS has posted information on the Competitive Bidding Implementation Contractor (CBIC) website [to](#) clarify its policy with regard to mail order suppliers. This posting provides further guidance on common carriers and local storefront suppliers. Please visit the Supplier's FAQ section at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) for more information.

If the link above does not work, please type the url above into your web browser. Thank you.

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## 7. CMS Proposes Quality Improvements and Other Changes for OPPS and ASC Services for 2009

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that will update payment rates for calendar year (CY) 2009 and improve quality of services provided in hospital outpatient departments and ambulatory surgical centers (ASCs). The proposed rule builds on efforts across Medicare to transform the program into a prudent purchaser of health care services, paying based on quality of care, not just quantity of services.

The proposed rule will update rates paid under both the Outpatient Prospective Payment System (OPPS) and the ASC Prospective Payment System (ASC PPS), which will be in the second year of a four-year transition that aligns ASC rates with the ambulatory payment classification (APC) groups that are used to pay for services in hospital outpatient departments.

To read the entire CMS Press release issued today click here:

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

To read the CMS Fact sheet issued today click here:

[http://www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp)

For more information on the CY 2009 proposals for the OPPS and ASC payment system, please see the CMS Web site at:

OPPS: <http://www.cms.hhs.gov/HospitalOutpatientPPS/>

ASC payment system: <http://www.cms.hhs.gov/ASCPayment/>

If you cannot access any of the links in this email, copy and paste the url into your web browser.

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## 8. Expiration of Therapy Cap Exceptions

The exceptions to outpatient therapy caps expire on June 30, 2008. Outpatient therapy service providers should not submit claims with the KX modifier for services furnished on or after July 1, 2008. To the extent possible, CMS is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of outpatient physical therapy, occupational therapy and speech-language pathology claims for services furnished by physicians, non-physician practitioners, and therapists paid under the physician fee schedule, beginning July 1.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1810. For occupational therapy services, the limit is \$1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Therapy cap accruals began on January 1, 2008, and some patients may have reached the annual limits by June 30, 2008.

Providers may access the accrued amount or remaining amount of therapy services from the Medicare beneficiary eligibility inquiry and response transactions. Specifically:

- For CWF users, the system returns the “applied” amount. See CR4115 at <http://www.cms.hhs.gov/transmittals/downloads/R759CP.pdf>
- For users of the HETS 270/271, the system returns the “remaining” amount. See the page 18 of the 270/271 user guide at <http://www.cms.hhs.gov/HETSHelp/Downloads/HETS%20270-271%20User%20Companion%20Guide.pdf>
- The Medicare contractors’ Interactive Voice Response units (IVR) return either the remaining or applied amounts based upon contractor programming. For those few contractors that do not provide this information on their IVRs, providers can call the contractors’ customer service representatives.

For additional information, Providers and Suppliers should also read the Medicare Claims Processing Manual, chapter 5, section 10. 2 at <http://www.cms.hhs.gov/manuals/downloads/clm104c05TXT.pdf>

#### **Patients Who Have Reached Their Limit(s) on Outpatient Therapy Services:**

Note that patients who have reached their limit(s) on outpatient therapy services, other than those who reside in a Medicare-certified part of a skilled nursing facility, may obtain medically necessary therapy services that exceed the caps if the services are furnished and billed by the outpatient department of a hospital. In other settings, outpatient therapy services in excess of the caps are not covered, and the therapy provider may charge for those services. An Advance Beneficiary Notice is recommended, but not required for services that exceed therapy caps. An ABN is available at the following link: [http://www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp#TopOfPage](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage) (click on ABN-CMS-R-131 Form). In the box titled "Reason Medicare will not pay" the following language is suggested Medicare will not pay more than \$1810 for expenses incurred for physical therapy and speech-language pathology services combined or for occupational services in 2008.

Patients may be referred to this website for further information:

<http://www.medicare.gov/Publications/Pubs/pdf/10988.pdf>

CMS will continue to be in communication with you with further information about payment of Medicare physician fee schedule claims. In addition, be on the alert for more information about other legislative provisions which may affect you.

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## **9. Extra Help for Beneficiaries Paying for Prescription Drugs**

### **Do You Know Someone Who Is Having Trouble Paying For Prescription Drugs? Medicare Can Help!**

- If an individual has limited income and resources, they may qualify for extra help from Medicare. It could be worth over \$3,300 in savings on prescription drug costs per year.
- Encourage people with Medicare to file for Extra Help online: <https://s044a90.ssa.gov/apps6z/i1020/main.html> or by calling Social Security at 1-800-772-1213 to apply over the phone.

- State Health Insurance Information Program (SHIP) offices can assist with the application. Find contact information for a local SHIP Counselor at <http://www.medicare.gov/contacts/static/allStateContacts.asp> or by calling 1-800-MEDICARE.

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