

CMS/SC IMPORTANT INFORMATION:

[ALERT – SPECIAL BIDDERS CONFERENCE FOR DMEPOS COMPETITIVE BIDDING PROGRAM!](#)..... Page 2

[Medicare Physician Fee Schedule Proposed Rule](#) Page 3

[New Outpatient Code Editor Resources](#) Page 4

[Web Posting of American Medical Group Association \(AMGA\) Survey Data](#) Page 5

[Participating CAP Physician Training](#)..... Page 6

[HHS Demonstration to Fight DME Fraud](#)..... Page 7

[NPI Update ~ New NPI Educational Products Available](#)..... Page 8

[CMS Release of Modifications to the HCPCS Code Set](#) Page 9

[Reporting on the 2007 PQRI Begins!](#) Page 10

[More PQRI AudioConference Opportunities for Region VI](#)..... Page 11

[Open Door Forum Updates](#) Page 12

[Tamper Resistant Prescription Pads](#)..... Page 14

ALERT – SPECIAL BIDDERS CONFERENCE FOR DMEPOS COMPETITIVE BIDDING PROGRAM

The Centers for Medicare & Medicaid Services (CMS) is holding a special 30 minute bidders conference call at 1:00 p.m. CENTRAL Time on July 9, 2007, to address issues associated with the bidding process for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Participant Call-in Number: (877) 356-8073, passcode 6553095

CMS is announcing a special bidders conference to discuss issues associated with the DME competitive bidding process. In the meantime, bidders should be aware that the Competitive Bidding Submission System (CBSS) automatically logs users out of the system after 2 hours due to a systems security setting built into the bidding process. At the special conference call CMS will discuss measures to expedite the overall bidding process and to manage data entered into the system.

Please be advised that suppliers should track their time while in the CBSS system. At the time at which a supplier is in the system for approximately 1 hour and 45 minutes, the supplier should save their data and log off the system entirely. After completely exiting the system, the supplier can go back and begin another session on the application.

In addition, suppliers should ensure that they keep their bidding session active by sending information to the server at least every 30 minutes. Suppliers should press the "update" or "submit" button on their current page or they should visit their home page by clicking on the "home" link on the top left corner of the application.

For more information on the program, please visit <http://www.dmecompetitivebid.com>

**CMS PROPOSES POLICY, PAYMENT CHANGES
FOR PHYSICIANS' SERVICES IN 2008**

The Centers for Medicare & Medicaid Services (CMS) projects that it will pay approximately \$58.9 billion to 900,000 physicians and other health care professionals in calendar year (CY) 2008, under a proposed rule released today that would revise payment rates and policies under the Medicare Physician Fee Schedule (MPFS). This proposed rule is a further step in Medicare's efforts to ensure that payment policies provide incentives to improve the quality of care.

Comments will be accepted on the proposed rule until August 31, 2007, and a final rule will be published later in the fall. The final rule will be effective for services on or after January 1, 2008.

The proposed rule (CMS-1385-P) can be viewed on the CMS Website at <http://www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/CMS-1385-P.pdf>

The Press Release can also be obtained on the CMS Website at http://www.cms.hhs.gov/apps/media/press_releases.asp, and the Fact Sheet is posted at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

New Outpatient Code Editor (OCE) Resources are Available on the CMS Website!

The Outpatient Code Editor (OCE) processes outpatient Medicare claims from/for all institutional providers. Understanding the OCE is important to institutional providers because the OCE performs three major functions:

- Edits the outpatient claim data to identify coding errors
- Assigns an Ambulatory Payment Classification (APC) number for each service covered under OPSS, and return information to be used as input to a Pricer program.
- Assigns an Ambulatory Surgical Center (ASC) payment group for services on claims from certain non-OPSS hospitals.

Effective for claims with dates of service July 1, 2007 and later, the non-Outpatient Prospective Payment System (non-OPSS) OCE will be integrated into the OPSS OCE. The resulting Integrated OCE will be used by Fiscal Intermediaries to process outpatient claims from both OPSS and Non-OPSS hospitals.

Claims from Non-OPSS hospitals with dates of service prior to July 1, 2007 will be routed through the last non-integrated update of the Non-OPSS OCE software (OCE v22.2) and will process with the versions in effect for the date of service on the claim.

Editing that was only applied to OPSS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to non-OPSS hospitals at this time. However, with the integrated OCE, non-OPSS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

In order to understand the OCE and to stay up-to-date with changes, providers are encouraged to:

- Visit the OCE webpage at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS web site and review the various sections;
- Review the OCE transmittal that is issued quarterly in order to identify any changes (OCE is updated generally at the beginning of January, April, July, and October); and
- Take the OCE web-based training course at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS Website. (A July 2007 version of this course is under development.)

American Medical Group Association Survey Data

In the May 11, 2007 Federal Register we stated that we would be posting on the web, the American Medical Group Association (AMGA) survey data to be used in determining the teaching physician portion of costs for "all or substantially all of the costs for the training program in the non-hospital setting." Since publication of the final rule, we have revised our web posting of the AMGA survey data to include the salary data for both dentists and podiatrists. The AMGA data can be found at http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp

Participating CAP Physician Training

Noridian Administrative Services, the designated carrier for the CAP, offers interactive, online workshops about the CAP for Part B Drugs and Biologicals. These workshops train participating CAP physicians on a variety of CAP topics, and NAS staff can also answer questions. Interested parties may view additional information about and register for these workshops at

https://www.noridianmedicare.com/cap_drug/train/workshops/index.html

Upcoming workshops will be held on the following dates:

- 7/10/07 at 11:00 am CT
- 8/8/07 at 2:00 pm CT
- 9/12/07 at 2:00 pm CT
- 10/18/07 at 12:00 pm CT

**HHS Fights Durable Medical Equipment Fraud:
Demonstration Project Targets Fraudulent Business Practices
in South Florida and Southern California**

HHS Secretary Mike Leavitt today announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment, prosthetics and orthotics supplies (DMEPOS). The initiative is focused on preventing deceptive companies from operating in South Florida and Southern California.

The new initiative will have immediate effect in two regions of the country where there is a high concentration of suppliers, South Florida and Southern California. Based on the results of the project, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare Fraud Strike Force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the Southern District of Florida with fraudulently billing Medicare for more than \$258 million. The strike force is made up of federal, state and local investigators.

For your convenience, I have attached copies of the HHS Press Release and Fact Sheet on this topic. These documents will also be posted on the HHS Website at <http://www.hhs.gov/news> .

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

New *MLN Matters* Article Available!

A new Special Edition *MLN Matters* article is now posted on the CMS website with important information for Medicare providers and suppliers. Some of the topics include:

- Common Enumeration Errors in NPPES
- Dos and Don'ts When Reporting "Other Provider Identification Numbers" in NPPES
- How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC
- How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs
- Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only

You can view this article by visiting

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf> on the CMS website.

June 14, 2007 NPI Data Dissemination Roundtable Transcript Available Now

The transcript for the 6/14/2007 NPI Data Dissemination Roundtable can be found at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/6-14NPITranscript.pdf> on the CMS website.

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 at the CMS NPI webpage located at www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

CMS Release of Modifications to the HCPCS Code Set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. This release includes 2 new modifiers required on claims billing Erythropoiesis Stimulating Agents (ESA) for in-center dialysis patients, in addition to 3 new modifiers required on claims billing ESAs for all non-ESRD related indications. These are necessary to implement the revisions to the ESA Monitoring Policy and the anemia reporting requirements of the 2006 Tax Relief and Health Care Act (TRHCA) respectively.

These changes have been posted to the CMS website at:
http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp
(View the first download under "Other-Codes.") The 5 new modifiers are effective on January 1, 2008. There are no new changes in this update effective October 1, 2007.

Reporting on the 2007 Physician Quality Reporting Initiative (PQRI) Begins!

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 PQRI on claims for dates of service as of July 1, 2007, has begun. Eligible professionals can now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor.

Remember, all your informational needs can be met by visiting the PQRI website at, <http://www.cms.hhs.gov/PQRI>. Here you will find educational resources, including the PQRI Tool Kit, and links to our most Frequently Asked Questions (FAQs).

CMS also announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule. Included in the proposed rule is important information directly related to 2008 PQRI. To view or download the proposed rule, visit, <http://www.cms.hhs.gov/center/physician.asp>, click on CMS-1385-P, then go to page 402 of the document.

PQRI AudioConference Opportunities

Are you ready to begin reporting? As you are aware, PQRI began last weekend. If you still have not taken the time to participate in one of the recently scheduled PQRI calls, there are a few more available to you through the SharpWorkGroup. Also note that while these are titled to be for Region 4 or 8, Region 6 is helping to sponsor these calls as part of our southern consortium and you are encouraged to participate. Please see the attached flyer for more information and details on how to register.

Open Door Forum Updates:

SPECIAL OPEN DOOR FORUM: MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION PROJECT

Monday, July 16, 2007
1:30pm-3:30pm CENTRAL Daylight Time

The Centers for Medicare & Medicaid Services (CMS) will be hosting this Special Open Door Forum (ODF) to discuss the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project. The demonstration is mandated by section 302(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

The purpose of the demonstration is to determine whether competitive bidding can be used to provide quality laboratory services at prices below current Medicare payment rates.

Only laboratories meeting the requirements under the Clinical Laboratory Improvement Amendments (CLIA) program are eligible to participate in the demonstration by statute. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the demonstration or competitive bid area (CBA). The demonstration will set competitively bid fees in the CBA for tests paid under the Medicare (fee for service) Part B Clinical Laboratory Fee Schedule, with the exception of Pap smears, colorectal cancer screening tests (which are excluded from this demonstration by statute), and new tests added to the Medicare Part B Clinical Laboratory Fee Schedule during the course of the demonstration.

We have planned this Open Door Forum to share the DRAFT Bidder's Package (posted on the project webpage at <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20data&filterValue=Upcoming%20Demonstrations&filterByDID=2&sortByDID=3&sortOrder=ascending&itemID=CMS1198949&intNumPerPage=10>) and a tentative timeline for the project.

The DRAFT Bidder's Package includes information about the bidding process and other operational policies. CMS will then moderate an open discussion where ODF participants will have an opportunity to interact with CMS and our research contractor, Research Triangle Institute, International (RTI) in an informal dialog about the DRAFT Bidder's Package.

Open Door Forum Participation Instructions:

There are 2 ways to participate, by phone or in person.

1. To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID 2359678
(Persons participating by phone do not need to RSVP.)

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html>.

A Relay Communications Assistant will help.

2. To participate in person:

Your RSVP is required. Please send a reply to CMS HOSPITALODF-L@cms.hhs.gov by 2:00 PM EDT, July 13, 2007. Be sure to include the title of the forum "Special Medicare Clinical Lab" in the subject line of your message, and send us your name, organization/representation and telephone number.

Upon entry into the campus and building, you will be required to show Government issued photo identification, preferably a valid driver's license, and are subject to baggage or vehicular search before entering the complex.

Please arrive no later than 1:30 PM.

ADDRESS:

Single Site Building

CMS Auditorium

7500 Security Boulevard

Baltimore, Maryland 21244

Map & Directions: <http://cmsnet.cms.hhs.gov/hpages/ocsq/cmsdirections-north.htm>

ENCORE: 1-800-642-1687; Conf. ID# 2359678

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID. This recording will be accessible beginning 2 hours after the conference has ended. The recording expires after for 4 business days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list registration) and to view Frequently Asked Questions please visit our website at: <http://www.cms.hhs.gov/opendoorforums/>

We look forward to your participation.

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An audio replay of the June 29, 2007 Special Medicare Provider Enrollment Open Door Forum can be accessed by dialing 1-800-642-1687 and keying in conference ID# 3630576 beginning Monday, July 2, 2007. The recording will be available for 4 business days, expiring on Friday, July 6, 2007. Also, you can download an audio replay of the conference by visiting the CMS Special Open Door Forum webpage at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp beginning July 5, 2007.

Tamper Resistant Prescription Pads & Other Medicaid News

Tamper-Resistant Prescription Drug Pads:

In a recent memo updating you on the provisions of the fiscal year (FY) 2007 supplemental appropriations measure (P.L. 110-28), we noted that Congress enacted a new provision mandating the use of Tamper-Resistant Prescription Pads in Medicaid. The effective date for this provision is October 1, 2007. We have heard from a handful of states with questions about implementation of this new provision and would like to share what we know to date.

Within CMS, the Medicaid Integrity Group for CMSO has authority for this provision. They have just begun to research how the new requirement intersects with existing policies. They do plan on issuing guidance prior to the effective date but they have not yet determined the format or scope for such guidance. NASMD has agreed to share with CMS questions and operational challenges that CMS may need to consider as it moves forward in this process.

REQUIREMENT FOR USE OF TAMPER-RESISTANT PRESCRIPTION PADS UNDER THE MEDICAID PROGRAM.—

1903 (i) – Payment under the preceding provisions of this section shall not be made: (23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad.

(2) EFFECTIVE DATE: The amendments made by paragraph (1) shall apply to prescriptions executed after September 30, 2007.
(See page 132 at: Sharp, Michael L (Mike))

Part D Clawback Payments and Penalty:

NASMD has learned that CMS is preparing to send notices to states via email about the Medicare Part D clawback payment. The letters will inform states of their October-December 2007 clawback multipliers reflecting the new federal medical assistance percentages (FMAPs) for FY 2008. Although they are expected shortly, CMS has not announced the specific date that the letters will be issued.

Regarding the payment penalty, if a State doesn't pay by the deadline on the 25th, CMS initiates an offset against the Medicaid grant. The State is also charged interest back to the first of the month on the amount due, if an offset is done. The billing guide (which all states should have received) specifies that the interest rate is the SMI trust fund rate for new investments per Section 1841 (c) of the act; applied in 30-day increments over a 360 day year based on Treasury Manual 1 FTM 6-8000... (See Fed Reg Volume 50, number 189 pages 39784-39785). CMS plans to address this issue during the next State Coordinating Committee call.

Final rule on Medicaid AMP FUL is now on display...

CMS today put on display at the Federal Register a final rule that implements provisions of the Deficit Reduction Act of 2005 (DRA). The DRA established a new federal upper limit (FUL) calculation, which is the maximum the federal government

will pay to states in federal matching funds or federal financial participation (FFP) for multi-source drugs (generics) dispensed through state Medicaid programs. The new FUL is calculated at 250% of the lowest average manufacturer price (AMP) in a generic drug class. States may pay above or below the FUL for individual drug classes and still receive the full FFP as long as overall payments for multi-source drugs subject to a FUL are under the annual aggregate cap. Please see the CMS Press Release for more information.

Goals of the DRA... more appropriate payment for generic drugs and transparency

The DRA changes were prompted by a series of 2004 reports by both the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies were actually paying for those drugs. The GAO and OIG found that states were overpaying for drugs because they were using commercial drug pricing guides as the basis for setting state reimbursement levels. The investigation of these drug price "compendia" documented that these prices were artificially inflated, especially for generic drugs.

One goal of the DRA was to encourage states to pay pharmacies more appropriately for the estimated acquisition costs of generic drugs. Prior to the DRA, actual drug prices were considered proprietary information and were used by CMS solely to calculate rebates; even CMS was prohibited by law from disclosing AMPs. The DRA makes AMP available to the States to consider in determining their methods for setting reimbursement for drugs under the Medicaid Program.

CMS encourages states to pay pharmacies adequate dispensing fees...

While CMS is required by law to establish a FUL for multi-source drug payments, states retain the authority to set their own reimbursement levels and dispensing fees paid to pharmacists. Recognizing that the new FULs could result in some reduction in drug ingredient payments to pharmacies, CMS is actively encouraging states to evaluate whether the fees they pay pharmacies are adequate to compensate them for their costs in dispensing these prescriptions. The final rule provides for a new definition of "dispensing fees" which includes the pharmacy's costs of dispensing the drug including overhead and profit. In order to adjust dispensing fees, state Medicaid programs must submit a state plan amendment for federal approval. Dispensing fees receive a full federal match and are not limited by the new FULs.

What does the final rule do?

CMS received more than 1600 comments to the proposed rule and has implemented some changes to reflect these comments. Specifically, the final rule:

Revised the definition of retail pharmacy class of trade and wholesaler to better track the provisions of the DRA. For example, it clarified that sales to entities such as Pharmacy Benefit Managers (PBMs) and pharmacies serving nursing homes and assisted living facilities are excluded from the determination of AMP;

Added manufacturer coupons redeemed by an agent, pharmacy or entity acting on behalf of the manufacturer to the list of prices excluded from the determination of AMP;

Added that manufacturer vouchers and manufacturer-sponsored drug discount card programs are excluded from the determination of AMP;

Excludes outlier AMPs, meaning that the lowest AMP in a FUL group will be excluded if it is less than 40 percent of the next highest AMP (this is a change from 30% in the proposed rule);

Added that sales to home infusion and specialty pharmacies are included in AMP (sales to mail order pharmacies remain included in AMP);

Requires manufacturers to submit quarterly and monthly AMPs to CMS. Monthly AMPs are calculated in the same manner as the quarterly AMP, except the period covered is one month. This will allow for more frequent updates of the FUL. Further, manufacturers must estimate the impact of lagged price concessions using a 12-month rolling average.

Importantly, to assure a smooth transition in the implementation of the final rule, the regulation addresses two provisions as final with a comment period: (1) a policy that eliminates from AMP calculations any drug in an FUL that is priced significantly lower than other drugs in that category, the so-called "outlier policy;" and, (2) definition of AMP. This will allow CMS the benefit of further public comment as actual AMP numbers become available and the FULs are developed. Stakeholders have 180 days from the publication date to submit public comments. CMS will respond to the public comments at a later date.

When does the regulation become effective? The regulation takes effect on October 1, 2007. The first monthly AMP reporting period will be for October 1-31, 2007. Please note that this is a change in schedule; FULs will not become effective for pharmacy payment until January 30, 2008, rather than December 30, 2007 as previously reported. The new tentative schedule is forthcoming.

DMEPOS Competitive Bidding Program Deadline Extended...

The Centers for Medicare & Medicaid Services (CMS) announced Friday that it is extending the registration and bid submission deadlines for the first round of the Medicare DMEPOS Competitive Bidding Program. All bids from suppliers are now due by July 20, 2007 at 9:00 p.m. EDT, for the first round of the competitive bidding program. The original due date was July 13, 2007 at 9:00 p.m. EDT.

Suppliers interested in bidding must first register and receive a user ID and password before they can access the internet-based bid submission system. The registration deadline for the user ID and password is now July 7, 2007. Suppliers should register immediately to avoid a delay in being able to submit bids. The original registration deadline was June 30, 2007.

Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the

first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. Click [here](#) for a list of the CMS-approved Deemed Accreditation Organizations.

Clarification... Timeline for eRx Proposal

As stated in an earlier Medicare Rx Update, the proposed Physician Fee Schedule rule will likely become effective on or after January 1, 2008. However, the proposed elimination of the computer-generated fax exemption for all provider/dispenser transactions will not become effective until 1 year after the effective date of the CY 2008 PFS final rule, or on or about January 1, 2009.