

Open Door Forum Newsletter

Dec '02 / Jan '03

Volume 2, Issue 3

Hot Announcements!

'03 Medicare Physician Fee Schedule

The Numbers Are In!

2,164 teleconference lines were open to individual and group participants and 342 guests visited with the CMS Administrator and policy leaders during the November and December 2002 Open Door Forums.

To date, more than 13,000 guests have participated in the forums.

The final rule for the Medicare physician fee schedule for 2003, which specifies rates paid to physicians for more than 7,000 health care services and procedures ranging from routine office visits to complex surgical procedures was published in the Dec 31 *Federal Register* and will be effective on March 1, 2003. Services provided on or after Jan 1 and before March 1 will be paid under the 2002 fee schedule. For further details and implementing instructions, please click here:

www.cms.hhs.gov/manuals/pm_trans/AB02181.pdf

Although methodological adjustments employed by CMS translate into an additional \$14.5 billion in Medicare payments to physicians over the next ten years, the physician fee conversion factor will be reduced by 4.4 percent.

"CMS recognizes that this will be the second year in a row in which physician fees will be affected by a negative update for the conversion factor [and] because only Congress has the authority to fix the formula, we will continue work with them to fix the flaws in the formula as soon as possible," said CMS Administrator Tom Scully.

"We want doctors, and patients, to see Medicare as a trustworthy partner in providing quality services. Fixing the formula to provide an accurate update (which we think should be 1.6 percent for calendar year 2003) is essential to restoring that trust," said Administrator Scully.

CMS Clamps Down on Abusive Billing Practices

Particularly concerned about excessive claims for outlier payments – payments intended to partially reimburse hospitals when the costs of a case greatly exceed the payment rate under the Inpatient Prospective Payment System (IPPS), CMS recently announced new steps to protect Medicare from abusive billing practices by hospitals.

Hospitals found to have engaged in strategies to obtain excessively high Medicare outlier payments will be presumed to be billing for more than they are entitled to and will be referred to the CMS Program Integrity Unit for further investigation and, if warranted, to the Office of Inspector General.

In a stern warning, CMS Administrator Tom Scully said, "We will carefully scrutinize any billing trends or other indications of inappropriate reimbursement [and] any hospital billing very high outlier rates better be absolutely sure that they are right or they are likely to be very sorry."

Details on the review process we asked our fiscal intermediaries to conduct can be found here:

http://cms.hhs.gov/manuals/pm_trans/a02122.pdf and here: http://cms.hhs.gov/manuals/pm_trans/a02126.pdf

CMS will be issuing a regulation shortly to modify the current system.



Information Disclaimer: The information provided in this newsletter is only intended to be general summary information to the public. 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 and private organizations. 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 referenced.



Add-On Payments for New Technologies

As part of the 2000 Benefits Improvement and Protection Act (BIPA), CMS was required to establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. 66 FR 46902 established that cases using approved new technology would be appropriate candidates for an additional payment when:

- The technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries;
- The payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and
- Data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights

An add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case. PRICER will calculate the total covered costs for this purpose by applying the cost-to-charge ratio to the total covered costs of the discharge. Payment for eligible cases will be equal to:

- The full DRG payment; plus
- The lesser of either 50 percent of the costs of the new medical service or technology or 50 percent of the amount by which the total covered costs of the case exceed the DRG payment; plus
- Any applicable outlier payments if the costs of the case exceed the DRG; plus adjustments for Indirect Medical Education (IME), disproportionate share hospitals (DSH), and any approved new technology payment for the case plus the fixed loss outlier threshold

The costs of the new technology are included in the determination of whether a case qualifies for outliers. For specific examples of cases eligible for payment and effective / implementation dates of the new instructions, please click here:

http://cms.hhs.gov/manuals/pm_trans/A02124.pdf

Group Therapy Frequently Asked Questions (FAQs)

CMS constructed 11 frequently asked questions (FAQs) to respond to inquiries received after the Sep 13, 2002 Special Open Door Forum that addressed issues related to one-on-one and group therapy services provided under the Medicare Physician Fee Schedule. These FAQs apply to outpatient therapy services provided in independent practices, physician offices, hospitals, etc. The FAQs provide a summary of the types of questions we received related to clinical practice and Medicare payment policies. The FAQs do not represent any change in agency policy. Answers to these and other billing questions are readily discernible from the existing CMS issuances and other publications.

The FAQs can be found on our home-page at: www.cms.gov and at: <http://questions.cms.hhs.gov> under the "Physician" category and the newly created subcategory: "Outpatient Therapy Payment." The Nurses and Allied Health Open Door Subcategory also contains a link to these FAQs. Please take note of the complete list of CMS Assumptions and References used in constructing the FAQs, which are part of the full document found on the Therapy Resources Web-site page at: <http://cms.hhs.gov/medlearn/therapy/> A direct link to this document is located in each FAQ answer along with the relevant references.

In related news: The moratorium on financial limitations (caps) on therapy services required by the Balanced Budget Act of 1997 expired on January 1, 2003. On Dec 23, 2002, CMS informed contractors that instructions for the implementation of caps will be provided shortly in a Program Memorandum. Until instructions are received, contractors were instructed to continue processing claims in 2003 the same way they were processed in 2002. CMS expects to implement the provision of the law in a prospective manner later this year.

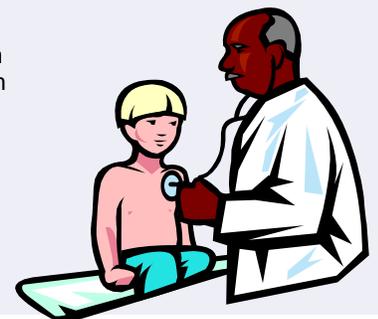
HHS To Expand Access To Care In Rural And Other Communities

Expanding upon the quality of care provided through existing efforts to add or expand health centers in 1,200 communities by 2006, HHS Secretary Tommy G. Thompson recently announced new regulations to ensure that qualified physicians are available in health professional shortage and medically underserved areas.

The new rules will allow HHS to review applications from community health centers, rural hospitals, and other health care providers to waive return-home requirements for foreign physicians who come to America for medical training so that they can remain in the country to practice in underserved areas. HHS would make recommendations on these requests to the State Department. The U.S. Immigration and Naturalization Service (INS) has the authority to grant waivers.

"By helping review these waiver requests, we can help increase the supply of qualified physicians available to provide needed care in community health centers and other locations in rural communities and other underserved areas," Secretary Thompson said. "Their contribution is critical to the success of our broader efforts to expand Americans' access to care."

HHS published the new regulations related to processing waiver requests in the Dec 19, 2002 Federal Register as an interim final rule with a 45-day public comment period. Public comments would be considered to make appropriate changes to the regulations. For more details, please click here: www.hhs.gov/news/press/2002pres/20021217.html



Glad You Could Make It!

Publicly Reported Nursing Home Quality Measures and Minimum Data Set (MDS) Coding Satellite Broadcast

On Dec 13, 2002, CBC staff coordinated a national nursing home quality measures and MDS coding satellite broadcast with CMSO, CMM, and OCSQ to provide MDS coding training on the quality measures. The broadcast responded to multiple training requests and questions from the Open Door Forum and other stakeholder and provider contacts. The target audience was nursing homes with Medicare or Medicaid certified units, nursing home provider associations, State Survey Agencies, CMS Regional Offices, Quality Improvement Organizations, State Long Term Care Ombudsman offices, and State Medicaid Agencies. MDS experts provided an overview of MDS items that reflect the Quality Measures, Resident Assessment Items (RAI) definitions for the MDS items that correlate with the Quality Measures and ways to improve accuracy in coding the Quality Measures of MDS items. Three CMS staff members answered questions received before the broadcast on the short stay and chronic quality measures.



There was great interest and a positive response to the broadcast. Of the 3,341 registered, 2,652 viewed the web cast, 409 sites viewed broadcast (5-50 viewers per site) and to date, 301 registered have registered for rebroadcast on the web. This program is available for viewing during the next four months at: <http://cms.internetstreaming.com> through April 15, 2003. The average pre-test scores for 10 MDS coding questions increased from 68 percent on the pretest to 94 percent on the post-test.



Hooray! The Medicare Coverage Database Is Here!

Use the new Medicare Coverage Database to gain comprehensive coverage information and answers to your coverage policy questions. The database will allow users to search National Coverage Determinations (NCD), National Coverage Analyses (NCA), and Local Medical Review Policies (LMRP).

The database, found here: www.cms.hhs.gov/coverage also contains information on coverage denial reviews; it, however, does not yet contain 100 percent of the LMRPs. Future changes to the site expected by this Spring will include more sophisticated searches and articles on coding and coverage topics.

CIGNA is Going Electric!

CIGNA HealthCare Medicare Administration (CIGNA Medicare), a CMS Medicare (Part B) and Durable Medical Equipment (DME) contractor, is reaching out to providers by taking advantage of decreasing technology costs. CIGNA Medicare has implemented two important provider communications tools on CD-ROM, along with an online interactive seminar and a new and improved E-mail Express Notification System (www.cignamedicare.com/Mailer/Subscribe.asp).

CIGNA Medicare released a Provider Enrollment CD-ROM in Oct 2002 in an effort to make the entire enrollment process easier for providers. Not only does the CD-ROM provide useful information for new and current providers, it also provides useful Web links to CIGNA Medicare's Web site (www.cignamedicare.com) and access to the provider application online at CMS' Web-site.

In addition, the first quarter FY03 Medicare Bulletin was released on CD-ROM and mailed to providers on Dec 30, 2002. Not only does the CD-ROM contain the most recent information, it also includes all of the Medicare Bulletin articles published in 2002. Future editions of Medicare Bulletin on CD-ROM will only build upon this information and will also contain updates about the latest workshops, HIPAA requirements, and all of the other resources providers need in one convenient place. Monthly editions of Medicare Bulletin and regular "What's New" updates will still be published online.

The most cutting-edge advancement recently implemented by CIGNA Medicare is the ongoing, interactive Webinar series. Webinars are live, interactive training sessions that may be viewed from a computer's Web browser and heard over a telephone line. The advantages of the Webinars include the convenience and cost reduction for providers and suppliers as well as CIGNA Medicare's Public Relations department. Seminars can be focused for smaller groups on specific educational topics. Upcoming topics include "HIPAA - as it relates to EDI," "Electronic Data Interchange (EDI) Basics," "Completing the CMS 1500 Form," and "Refractive Lenses." For more information, visit the Webinar Web site at: www.cignamedicare.com/wrkshp/dm

Finally, CIGNA Medicare has introduced a revised ListServ mailing list -E-mail Express Notification System - to improve instant communications with the provider and supplier community. Providers and suppliers can now get immediate e-mail updates on Part B Medicare Bulletins, DMERC Dialogues, supplier and provider manuals, workshops, and medical review information by subscribing to this revamped service.

With the assistance and approval of CMS, CIGNA Medicare has been able to keep in touch with the provider and supplier community, more quickly and more accurately, through the use of technology.

We Hear You!

Customer Satisfaction with Medicare's Program Integrity

CMS would like to share some results of an ongoing project designed to both identify baseline satisfaction with beneficiary and provider experiences with the key Program Integrity activities as well as identify priority improvement areas and potential service delivery changes that would result in improved customer satisfaction.

From the beneficiaries' perspective, CMS hoped to learn from their experiences with having reported billing questions transferred to the Fraud Unit and, from the providers, learn from their experiences with provider enrollment, focused pre-pay and post-pay medical review, and cost report auditing.

Results tallied thus far from a mail survey that included a sampling of providers served by the eight largest CMS contractors as well as providers who recently had enrolled, had a focused pre-pay or post-pay audit, or completed a cost report audit, indicated that there was an overall satisfaction index between 2.99 and 3.11 based on a 1 to 5 scale with 5 being "very satisfied."

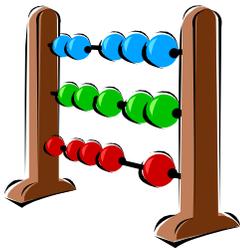
Among the areas for provider enrollment improvement included: CMS' need to give providers more information about the enrollment process via the web and print brochures, increase accuracy and consistency of answers given to providers in writing and by phone, and implement continuous improvement both at headquarters and within contractor organizations (local action planning); for medical review: CMS' need to make the rules easier for providers and call center staff to find and establish a Medicare Coverage Database (see page three of this newsletter) and, finally, regarding cost report auditing: CMS' need to identify ways to better answer providers' questions about current requirements and support auditors.

In terms of "where do we go from here" with survey data collected, CMS will conduct beneficiary and provider satisfaction surveys again in early 2003, will work with other Medicare divisions to develop a comprehensive customer satisfaction measurement strategy, and will use the provider enrollment improvement activities as models for pilots in other Medicare functions.



FY04 Hospital Wage Index Data

The FY04 Hospital Wage Index Data will be posted to the CMS Web-site as a Public Use File (PUF) on Friday, Jan 10, 2003. CMS Fiscal Intermediaries received notice detailing the wage index timeline, which includes the deadline of Feb 10, 2003 for submitting revisions of wage data to CMS.



In addition to the PUF, there will be a file comparing provider average hourly wages from last year to preliminary average hourly wages for this year. Any hospital using a special process [due to filing extensions for hospitals that have their claims processed through the APASS system (PM A-02-095, Oct 4, 2002)] to send in their wage data this year should be especially sure that their wage data is OK.

For more details, please visit: <http://cms.hhs.gov/providers/hipps/default.asp>

Hospital Billing Instructions for Immunosuppressive Drugs Furnished to Transplant Patients

CMS has issued Program Memorandum A-02-123 (http://cms.hhs.gov/manuals/pm_trans/A02123.pdf), which instructs all hospitals subject to the Outpatient Prospective Payment System (OPPS) to bill immunosuppressive drugs furnished to beneficiaries for use after discharge, e.g., 30-day supplies, to the Durable Medical Equipment Carrier (DMERC) effective Jan 1, 2003.

Hospitals subject to this PM must either already have a supplier number for billing the DMERC they must complete form CMS-855-S (cms.hhs.gov/providers/enrollment/default.asp) and submit it to the National Supplier Clearinghouse (NSC) to and obtain a supplier number. To reach NSC directly, please call (866) 238-9652

Once a hospital has its supplier number, it may use the CMS-1500 or electronic equivalent to bill the appropriate DMERC. The DMERC will base payments on the instructions in PM AB-02-075 (http://cms.hhs.gov/manuals/pm_trans/AB02075.pdf).

Reduced Burden Outcome and Assessment Information Set (OASIS)



Although CMS has not received formal clearance for the OASIS-B1 (Dec 2002), OMB Form 245, to implement the reduced burden OASIS, home health providers may begin to use the new form immediately. The OASIS state systems are prepared to accept OASIS assessment records from the current data set, OASIS-B1 (Aug 2000) using HAVEN 5.1 and the OASIS-B1 (Dec 2002) using HAVEN 6.0.

During this period, we are notifying the state survey agencies that no enforcement action will be taken regarding home health agency (HHA) use of either OASIS data set. We will notify you on the CMS/OASIS website when we obtain final clearance of the reduced burden OASIS.

Please note if you use HAVEN 5.1 and vendor software that is not upgraded to use the new grouper, agencies will receive warning message +257 on any assessments requiring a HIPPS code. This message will not occur when you have upgraded to the new grouper. Additionally, two reasons for assessment will no longer be accepted by the state systems. The two reasons are: reason for assessment 2, "Start of Care no further visits planned" and reason for assessment 10, "Discharge from agency, no further visits after the start of care". Agencies can continue to collect these two assessment time points and place the comprehensive assessment in the patient's clinical record until final clearance."

CMS expects to be able to announce clearance in the near future. We also understand that many agencies have installed HAVEN 6.0 to use the reduced burden data set and CMS did not want to burden them to remove it during this transition. Therefore, we have notified state agencies not to take enforcement action during this period. CMS intended that HHAs could implement burden reduction at any time, and the new OASIS data set would not be mandatory until Oct 2003.

Our help desk has been answering questions from agencies and helping them with transition issues. CMS will not require agencies who have implemented the reduced burden data set to complete alternative assessment forms during this transition; for example, if an agency is completing the reduced burden follow-up - only the 26 items- we would not require completion of the full complement of 92 items.

If agencies have issues or questions, please contact the OASIS / Haven Help Desk at (877) 201-4721 or Haven_Help@IFMC.org. For CMS' OASIS resource page, please click here: <http://cms.hhs.gov/oasis/default.asp>

Medicare Single Drug Pricer for Medicare Covered Drugs

CMS has provided implementing instructions, which describe a procedure for identifying uniform, consistent payment allowances to ensure that physicians and other practitioners receive the same payment for the same drug regardless of where their claim for the drug is submitted.



The instructions, found in Program Memorandum AB-02-174 (http://cms.hhs.gov/manuals/pm_trans/AB02174.pdf), apply to all Medicare covered outpatient drugs for which the Medicare payment allowance is based on 95 percent of the average wholesale price (AWP) except for drugs billed to durable medical equipment carriers (DMERCs) and hospital outpatient drugs billed to

fiscal intermediaries (FI).

DMERC-paid drugs are excluded because these drug payment allowances are already consistent nationally. Hospital outpatient drugs are excluded because the payment allowance for such drugs is determined by a different procedure from that described in PM AB-02-075 (http://cms.hhs.gov/manuals/pm_trans/AB02075.pdf).

State Waiver Programs and Demonstrations

Want to know the details about state waiver or demonstration program near you? Well be sure to click on the map below to be directed to CMS' up-to-date resource on such matters. Detailed resources for everything from 1115, Pharmacy Plus, Freedom of Choice [1915(b)], Home and Community-Based Services [1915 (c)], and 1915(b)/(c) Combination waivers to the full list of Comprehensive Health Care Reform Demonstrations and the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative can be found just by visiting: www.cms.hhs.gov/medicaid/waivers



Don't Be Left Out!

Register for the CMS
Open Door Forum ListServ

To encourage consistency and efficiency in delivering announcements, invitations, schedules and other important news through the Open Door Forums, CMS has made it even easier for you to get involved. Notifications of the meetings will be distributed via the new Open Door Forum ListServ in the form of e-mail messages. As a registrant, you will receive notification of forums and relevant information pertaining to the forum(s) you have selected. The menu on the website displays 12 forums. Each title is a link to the specified registration page. Everyone is required to subscribe to each forum(s) of their interest. To register, click here:
www.cms.hhs.gov/opendoor/listservs.asp
and follow these important steps:

1. Select the forum(s) list you would like to join;
2. Enter your correct e-mail Address;
3. Enter your First and Last Name;
4. Click "Join the List"

Note that if you are currently receiving notifications of the forums by direct e-mail, please RE-REGISTER via the Listserv by January 31, 2003.

Forum Flash!

Philip Mangano, executive director of the U.S. Interagency Council on Homelessness, joined us at our Low-Income Health Access Open Door Forum held in Dec, which was co-hosted by Administrator Tom Scully, CMS, and Administrator Elizabeth James-Duke, PhD, Health Research and Services Administration. Mr. Mangano's participation marked the strengthening of the relationship that CMS and the Council have toward working together to eradicate chronic homelessness and discuss supportive health care issues toward that end. In related news, HHS Secretary Tommy G. Thompson has been designated the incumbent Council chair 2003.

- As a reminder note, the Health Plans Open Door Forum, chaired by Gail P. McGrath, Director, Center for Beneficiary Choices, will be held at 2 pm EST in New York City on Jan 16, 2003 –be sure to register on the ListServ!

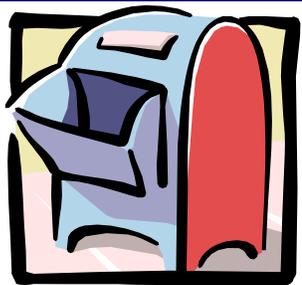
- Don't forget! Ruben King-Shaw Jr., CMS' Chief Operating Officer and Deputy Administrator (seen at the Wake Forest University School of Medicine in the picture to the right) will host our Jan 27, 2003 Physician Open Door Forum in Boston, MA with help from the Massachusetts Medical Society. To learn more about how to host a forum in a town near you, please see the contact info to the bottom left.



Hot Transmittals!

- 2003 Update of the Hospital Outpatient Prospective Payment System (OPPS): http://cms.hhs.gov/manuals/pm_trans/A02129.pdf
- Provider Notification of Denials Based on Local Medical Review Policy (LMRP): http://cms.hhs.gov/manuals/pm_trans/AB02184.pdf
- Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities: http://cms.hhs.gov/manuals/pm_trans/AB02183.pdf
- Revisions to Common Working File Edits for Skilled Nursing Facility (SNF) Consolidated Billing (CB) to Permit Payments for Certain Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End Stage Renal Disease (ESRD) at an Independent or Provider-Based Dialysis Facility: http://cms.hhs.gov/manuals/pm_trans/AB02175.pdf

For any information regarding the Open Door Forum Initiative, please feel free to contact Tom Barker, Special Assistant to the Administrator for Policy and Outreach at (202) 690-0056 or: tbarker@cms.hhs.gov



Quick Notes on HIPAA

On Jan 15, 2003, CMS hosted the Sixth Health Insurance Portability and Accountability Act (HIPAA) Implementation Roundtable conference call designed to provide information regarding the implementation of the Administrative Simplification provisions. Among the many topics discussed were updates on the status of the HIPAA regulations, enforcement issues, new resources, and the latest information from HHS' Office for Civil Rights (OCR) on the HIPAA Privacy Rule.

CMS and OCR staffs were on hand to answer questions from the more than 2,200 participants on the call. Please stay tuned to our website at www.cms.hhs.gov/hipaa/hipaa2/default.asp for announcements of future HIPAA Roundtables. For more details on these and other HIPAA events and to locate additional resources, please feel free to contact the CMS HIPAA Hotline at: (866) 282-0659.

OCR will convene four National Conferences on the HIPAA Privacy Rule. These one-day conferences are designed to provide an unprecedented opportunity to hear from and interact with officials who developed the HIPAA Privacy Rule and will be responsible for interpreting and enforcing the rule. To register for a conference near you, please click here: www.hhs.gov/ocr/conference.html