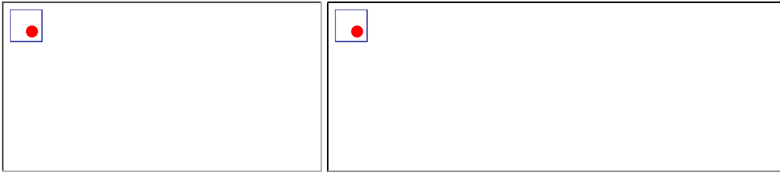

Go to HBMA Website

Washington Report – May, 2007

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TOP

CMS releases NPI Dissemination Notice
Physician Payments and the Search for Medicare Savings
Other Medicare, Medicaid and S-CHIP Spending Options
Testing Opportunity for the Physician Quality Reporting Initiative
Weems Nominated to be next CMS Administrator
HIPAA: What it is, What it ISN'T
Medicare to Expand Coverage of Ultrasound Diagnostic Procedures
CMS Program Transmittals Released in April and May

To the top

CMS Releases NPI Dissemination Notice

On May 30, the Centers for Medicare and Medicaid Services (CMS) released the long-awaited dissemination notice that permits the government to make the NPI database publicly available.

The Notice describes the policy by which CMS will make certain health care provider data available to covered entities under the Health Insurance Portability and Accountability Act (HIPAA).

According to the notice, CMS will make the database available in electronic form through the internet. Specifically, the data will be available in downloadable files **and** in a query-only database. Billing companies needing access to this information will be able to go to the website and do either an individual search, or download the entire database. CMS will update the database on a monthly basis. The web address where this information will be located has not been released and will not be released until closer to the effective date. When the web address is released, a link will appear in the NPI section of the CMS website:

http://www.cms.hhs.gov/NationalProvIdentStand/

HBMA will alert members once the database link is announced.

CMS is encouraging all providers to review the NPI data (and associated data) to ensure its accuracy. The actual database will not go on-line until 30 days after publication of this notice so that providers have an opportunity to review the information and verify that it is correct.

According to the Federal Register notice, in addition to providing the NPI, the following information may be disclosed as part of the data dissemination process.

Entity Type Code: 1=Individual 2=Organization	Employer Identification Number (EIN)
Provider Name (First, Last and Middle, as well as Prefixes and Suffixes) (Other providers names as well)	Provider Credential Text
Provider Business Mailing Address, telephone and fax	Other Provider Business Location Addresses, telephone and fax
Healthcare Provider Taxonomy Code (Primary Taxonomy required; up to 15 may be reported)	Other Provider Identifier
Other Provider Identifier Type Code	Provider Enumeration Date
Last Update Date	NPI Deactivation Reason Code
NPI Deactivation Date	NPI Reactivation Date
Provider Gender Code	Provider License Number
Provider License Number State Code	

Because some of this information is voluntary, not mandatory, the provider has the option of removing the voluntary information from the NPPES database.

The Department of Health and Human Services has determined that Social Security Numbers (SSNs), IRS Individual Taxpayer Identification Numbers (ITINs), and dates of birth (DOB) will NOT be disclosed.

HBMA will alert members once the database link is announced. HBMA members may wish to contact their physician clients and encourage them to review the information in the NPI database to verify its accuracy and remove any information they do not wish to have shared with others.

To the top

Physician Payments and the Search for Medicare Savings

Under the general Rules by which Congress operates, no new spending can take

place unless Congress either passes a tax increase or pay for the new spending OR cuts spending in other government programs to offset the new spending. This is referred to as "PAYGO" or Pay-as-you-Go. In addition, there are specific Medicare spending rules that stipulate if physician spending exceeds a preset budgetary target for a given year, payments must be reduced in the subsequent year to offset those larger than expected increases. This is known as the Sustainable Growth Rate formula or SGR.

As has been previously reported, current budget projections indicate that the SGR rules will require a 10% reduction in the physician fee schedule payments beginning January 1, 2008 because of higher than expected Medicare Part B expenditures in 2007. Similar reductions have been called for under the SGR program; however, Congress has always intervened to prohibit these reductions from actually taking place. You will recall that there was a scheduled 5.1% SGR related reduction scheduled to take effect on January, 1 2007; however, Congress enacted legislation in the waning hours of 2006 which prevented this cut from occurring and instead, froze Medicare Part B fee schedule payments at the 2006 level.

In order for Congress to intervene to prevent the 10% SGR related cut from occurring on January 1, 2008, the PAYGO budget rules require Congress to either raise taxes sufficiently to offset this "new" spending OR make spending cuts in the Medicare program sufficient to cover the cost of preventing the SGR cuts. The Congressional Budget Office (CBO) has estimated that it will take between $23 and 30 Billion in either tax increases or Medicare spending cuts (or a combination of the two) to fully pay for the SGR fix in 2008.

The budget and policy rules mean that it is simply not enough for Congress to reach consensus on preventing the SGR cut. That's the easy part as evidenced by the strong, bi-partisan agreement that cuts of this magnitude would be devastating for both providers and patients. The hard part is maintaining the bi-partisan consensus for fixing this problem when you start considering various options for paying for the fix.

To the top

Other Medicare, Medicaid and S-CHIP Spending Options

Many in the new Congressional leadership have expressed a desire to make other changes in the Medicare, Medicaid and State Children's Health Insurance Programs (S-CHIP) that would result in higher spending. As with the SGR issue, these, too, must be paid for under the PAYGO rules.

For example, the House and Senate Democratic leadership have called for an expansion of the S-CHIP program to include more children and some families. Many in Congress have indicated their support for a repeal of the drastic cuts in imaging payments that took effect two years ago. Additionally, other providers are seeking new or expanded coverage for certain services.

Adopting all or even just some of these proposals will result in higher Medicare spending than contemplated by the Budget. If Congress wants to make these changes, then it must find the resources to accomplish this object – either tax

increases or other spending cuts in the Medicare or Medicaid program.

While in the past, tax increases have been off the table, this does not seem to be the case during the 110th Congress. There is increasing talk about raising the federal cigarette tax to help pay for expansion of the S-CHIP program. Congressional support for raising this tax is growing and Public Health and anti-smoking advocates have been pushing this option vigorously. According to the Congressional Budget Office, raising the cigarette tax by 50 cents per pack would generate $26.6 Billion in revenue. Cigarette manufacturers appear to be engaged in only token opposition. Not surprisingly, one of the strongest opponents of raising the federal cigarette tax are the cigarette manufacturers. What you may find surprising, is that they have been joined by many of our nation's Governors.

Lest you think the Governors have suddenly become pro-smoking, their opposition is driven by their own fiscal self interest. States are generating a tremendous amount of revenue from their state cigarette taxes and they are fearful that raising the federal tax will either prevent them from further raising the state cigarette taxes OR actually have the effect of discouraging more people from smoking. In a perverse way, the entities that benefit from the revenues raised by cigarette taxes don't really want everyone to stop smoking. So while the Governors support cigarette taxes, they don't want them so high that people actually stop smoking.

There is also the option of reducing spending. Along these lines, the Congressional Budget Office has produced a list of options Congress might want to consider as it seeks to address the SGR problem, as well as other Medicare changes Congress wants to contemplate. A sampling of that list is below. If you would like to see the entire list of possible savings, as well as possible tax options, go to:

http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf

Each year, the Congressional Budget Office establishes the "baseline" spending target for Medicare spending for the current fiscal year and an average percentage growth for the next 5 years. According to the CBO, Medicare spending is expected to be $370.2 Billion in 2007 with an average annual rate of growth of 9.3 percent over the next 5 years. Approximately $60 Billion of this spending will be paid for by beneficiary premiums, recovered overpayments and state contributions.

Options for Reducing Medicare Spending

Option	Savings	
	One year Savings	Five Year
Adjust MA Plan Payments to equal local per Capita fee-for-service spending	$8.1 Billion	$64.8 Billion
Reduce Graduate Medical Education Payments	$1.0 Billion	$5.2 Billion
Reduce Indirect payments to hospitals for Hospital Teaching	$3.9 Billion	$21.6 Billion

program		
Increase Part D Premium for high income elderly	$150 Million	$2.8 Billion
Impose a deductible and coinsurance for Lab	$1.6 Billion	$8.3 Billion
Equalize Capital-related Payments for teaching and non-teaching hospitals	$400 Million	$2.3 Billion
Remove Medicare's payments for Indirect Medical Education from MA Plan payments	$700 Million	$5.2 Billion
Total	$15.85 Billion	$110.2

Although not included in the CBO analysis, another "savings" option under consideration is a slight reduction in the amount of the increase hospitals will receive in 2008. Hospital payments are schedule to rise in 2008 reflecting medical inflation (MI). Although the actual number is not known at this time, it will likely be between 2 – 3 percent. This proposal would limit the inflationary increase to MI - one. So if the formula says the MI increase should be 3%, this proposal would limit it to 2% (3% - 1% = 2%)

Rep. Pete Stark (D-CA), Chairman of the Ways & Means Health Subcommittee has indicated his desire to significantly reduce MA plan payments along the lines of the CBO proposal. It is not clear whether any of the other options have any significant support.

To the top

Testing Opportunity for the Physician Quality Reporting Initiative

Eligible professionals interested in testing their billing system, and practice their readiness for PQRI quality data code reporting, will have a chance to do so. CMS has designated "G8300" as a test code for PQRI reporting prior to July 1, 2007, the start date for PQRI reporting. G8300 was formerly used in the 2006 PVRP program and will be retired on July 1, 2007; meaning it will be rejected on any claims submitted for dates of service on and after July 1, 2007. In the interim, it can be used to test readiness as follows:

1. Add the G8300 test code as a line item on any claims for services. On the ASC X12N health care claim transaction (version 4010A1), submit the HCPCS code G8300 in the SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

For claims submitted on the CMS 1500 Form, report the test code in field 24D.

2. Randomly enter "$0.00 or "$0.01" as the line item charge for the test code. This will confirm the ability of billing software or clearinghouses to accept either.

3. Check your Remittance Advice (RA) for these claims to assure the test code has been passed through and processed by the carrier or MAC. You should see

Claim Adjustment Reason Code message 96, "Non-covered charge(s)." Also, you will see Remittance Advice Remark Code message N365, "This procedure code is not payable. It is for reporting/information purposes only." The RA will serve as your feedback for the test. CMS will not issue any other feedback.

4. The RA will indicate that the test code was denied. The test code will also show up on the beneficiary's MSN with the statement "This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount." This same message will be appear on MSNs during the 2007 PQRI reporting period for designated 2007 PQRI codes.

To The Top

Weems Nominated to be next CMS Administrator

Kerry Weems, a long-time employee of the Department of Health and Human Services (HHS), has been nominated by President Bush to be the next Administrator of the Centers for Medicare and Medicaid Services (CMS). Weems has been serving as the Deputy Chief of Staff for the Secretary of HHS and prior to that appointment, he was Assistant Secretary of Health and Human Services for Management and Budget.

In a press release issued shortly after the announcement that Weems was President Bush's choice, HHS Secretary Leavitt had this to say about Weems, "He understands the large fiscal challenges facing Medicare and Medicaid and what it will take to strengthen and sustain those programs for the future. Further, he has been a leader in this department's efforts to accelerate adoption of health information technology and better financial management systems, which will be a valuable asset to CMS."

Although Weems' experience in the agency is extensive, his published bio demonstrates little involvement with Medicare or Medicaid – other than reviewing budgets. Many outsiders believe Weems was nominated because he would be non-controversial and could get approved by the Senate (the position requires Senate confirmation).

Nomination hearings have not yet been set for Weems; although it is likely the hearings will occur some time this summer.

To the top

HIPAA: What it is, What it ISN'T

Over the years, a myriad of problems have been laid at the feet of HIPAA. Providers and payers have both used HIPAA as an excuse for why they couldn't do something a physician, hospital, patient or family member of a patient wanted done. Now, CMS has published a document entitled: **What HIPAA Does and Does Not Do.** The purpose of this document is to try to dispel some of the myths surrounding HIPAA and also make sure people know where the HIPAA laws can be of assistance.

A copy of the document follows. If you would like to learn more, you can go to the CMS website and read more about HIPAA. Go to:

http://www.cms.hhs.gov/HealthInsReformforConsume /02_WhatHIPAADoesandDoesNotDo.asp

What HIPAA Does and Does Not Do

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes important - but limited - protections for millions of working Americans and their families. HIPAA may:

1. Increase your ability to get health coverage for yourself and your dependents if you start a new job;
2. Lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
3. Help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
4. Help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Among its specific protections, HIPAA

1. Limits the use of pre-existing condition exclusions;
2. Prohibits group health plans from discriminating by denying you coverage or charging you extra for coverage based on your or your family member's past or present poor health;
3. Guarantees certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and
4. Guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.

In short, HIPAA may lower your chance of losing existing coverage, ease your ability to switch health plans and/or help you buy coverage on your own if you lose your employer's plan and have no other coverage available.

Misunderstandings About HIPAA

Although HIPAA helps protect you and your family in many ways, you should understand what it does NOT do.

1. HIPAA does NOT require employers to offer or pay for health coverage for employees or
   family coverage for their spouses and dependents;
2. HIPAA does NOT guarantee health coverage for all workers;
3. HIPAA does NOT control the amount an insurer may charge for coverage;
4. HIPAA does NOT require group health plans to offer specific benefits;
5. HIPAA does NOT permit people to keep the same health coverage they had in

their old job
when they move to a new job;
6. HIPAA does NOT eliminate all use of pre-existing condition exclusions; and
7. HIPAA does NOT replace the State as the primary regulator of health insurance.

To the top

Medicare To Expand Coverage Of Ultrasound Diagnostic Procedures

The Centers for Medicare & Medicaid Services (CMS) has announced a decision to provide coverage for Doppler monitoring of cardiac output in certain settings. According to a release issued by CMS, the agency has "determined that the current evidence is adequate to revise its longstanding Ultrasound Diagnostic Procedures National Coverage Determination and remove the past noncoverage of this diagnostic test in these settings."

In announcing the decision, CMS Acting Administer Leslie V. Norwalk, Esq. said, "Today's decision reflects CMS' commitment to using evidence-based approaches to provide Medicare beneficiaries with reasonable and necessary medical technologies as they evolve through innovation in the marketplace. As we developed this decision, we used the best available medical evidence—in the form of randomized controlled clinical trials—to re-evaluate our position on this important non-invasive method of caring for patients in intensive care situations."

CMS will amend the National Coverage Determination (NCD) "Ultrasound Diagnostic Procedures" at section 220.5 of the NCD manual by adding "Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization" to the list of covered uses.

CMS' decision was effective May 22nd, and is available online at

https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=196.

To the top

CMS Program Transmittals released in April and May

The following program transmittals were issued by the Centers for Medicare and Medicaid Services between April 23, and May 31, 2007.

CMS uses transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes.

Transmittal #	Subject	Effective Date
R207PI	Discontinuance of the Unique Physician Identification Number (UPIN) Registry	06/29/2007

R1253CP	Quarterly Update to Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007	07/02/2007
R1252CP	Clarification of Skilled Nursing Facility (SNF) No Pay Billing	08/27/2007
R1250CP	Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims	10/01/2007
R71BP	Clarification of Manual Instruction Regarding Scope of Portable X-Ray Benefit	07/02/2007
R1248CP	Revisions, in the Medicare Claims Processing Manual, to Section 40, titled, "Discarded Drugs and Biologicals," and Section 100.2.9, titled, "Submission of Claims With the Modifier JW, 'Drug Amount Discarded/Not Administered to Any Patient.'"	07/02/2007
R1257CP	Important Message from Medicare (IM) and Expedited Determination Procedures for Hospital Discharges	07/02/2007
R1254CP	National Uniform Billing Committee (NUBC) Update to Chapter 25	06/11/2007
R278OTN	Department of Veterans Affairs Medicare-equivalent Remittance Advice (MRA) Project: Continued Use of Part A Legacy Provider Numbers After National Provider Identifiers (NPIs) Are Fully Implemented	10/01/2007
R279OTN	Continuation of Legacy Number Reporting on Outbound Claims for COBA Process	07/02/2007
R280OTN	Adding Three CMS Specialty Codes for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	01/02/2008
R1251CP	Clarification of the National Provider Identifier (NPI) Reporting Requirements for Ambulance Service Claims	07/02/2007
R282OTN	Common Working File Informational Unsolicited Response--Analysis Only	10/01/2007
R1249CP	Update to Publication 100-4, Chapters 1 & 15 for ZIP5 and ZIP9 Medicare ZIP Code Files.	10/01/2007

R1247CP	New Deadline for Required Submission of the Form CMS-1500 (08-05)	07/02/2007
R203PI	Strategy Analysis Report (SAR)	07/02/2007
R278OTN	Department of Veterans Affairs Medicare-equivalent Remittance Advice (MRA) Project: Continued Use of Part A Legacy Provider Numbers After National Provider Identifiers (NPIs) Are Fully Implemented	10/01/2007
R1256CP	Update Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for Rate Year (RY) 2008	07/02/2007
R1255CP	Guidelines for Payment of Diabetes Self-Management Training (DSMT	07/02/2007
R72BP	Guidelines for Payment of Diabetes Self-Management Training (DSMT)	07/02/2007
R281OTN	Revision on the Medicare Summary Notice (MSN) Printing Cycle	10/01/2007
R122FM	CMS Reporting Requirements With the Exception of MSP for Unsolicited/Voluntary Refunds	06/25/2007
R204PI	Comprehensive Error Rate Testing (CERT) Program Changes	06/25/2007
R44GI	Fee-for-Service Contractor Transition Handbooks	07/02/2007
R1246CP	Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas	04/01/2008
R1242CP	Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)	10/01/2007
R1243CP	Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 13.2, Effective July 1, 2007.	07/02/2007
R277OTN	Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles	05/18/2007
R13P232	To reflect further clarification to existing instructions and incorporates	N/A
R1241CP	Stage 3 NPI Changes for Transaction 835 and Standard Paper Remittance Advice	N/A
R202PI	Medical Review Re-openings	10/01/2007

R1244CP	New Waived Tests	07/02/2007
R69NCD	Bone Mass Measurements (BMMs)	07/02/2007
R70BP	Bone Mass Measurements (BMMs)	07/02/2007
R1240CP	Present On Admission Indicator	10/01/2007
R1239CP	Enhancements to Claims Processing Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals for the October 2007 Release	10/01/2007
R1236CP	Bone Mass Measurements (BMMs)	07/02/2007
R1237CP	Instructions for Downloading the Medicare ZIP Code Files - October 2007	10/01/2007
R201PI	Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier	12/03/2007
R432PR1	Inflation factors to update previous years reasonable compensation ranges.	N/A
R121FM	Contractor CROWD Form 5 Completion Changes	10/01/2007
R275OTN	New Contractor Workload Number for Cahaba Part A Iowa Data	11/01/2007
R276OTN	New Contractor Number for Jurisdiction 3 Arizona Part A Workload	10/01/2007
R53DEMO	Method of Payment for Extended Stay Services under the Frontier Extended Stay Clinic Demonstration, Authorized by Section 434 of the Medicare Modernization Act	10/01/2007
R1228CP	Instructions for Implementation of CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)	05/29/2007
R274OTN	Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from CWF.	07/02/2007
R69BP	Change to the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Discharge Bill	12/03/2007
R1231CP	The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective Payment System (IPF	12/03/2007

	PPS) and Clarification of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)	
R1234CP	Update of HCPCS Codes for Hemophilia Clotting Factors	10/02/2007
R1229CP	Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) and the ALJ Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands.	07/02/2007
R1233CP	Clarification of Bariatric Surgery Billing Requirements Issued in CR 5013	05/29/2007
R86MCM	Revisions to Chapter 17, Subpart B, Section 220, Determining Deductibles and Coinsurance	04/27/2007
R1232CP	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	10/01/2007
R200PI	Update Program Integrity Management Reporting (PIMR) System for Multi Carrier System (MCS) to Recognize New "T" and "F" Codes and to Expand the MCS Contractor Bill Type Code Table to Accommodate the New "T" and "F" Codes	10/01/2007
R85MCM	Revisions to Chapter 18 Subpart B Section 110, Determining Deductibles and Coinsurance	04/27/2007
R273OTN	Discontinuing the Application of Outpatient Frequency of Billing Edits to Roster Bills	10/01/2007
R272OTN	Medicare Claims System (MCS) Provider File Extract to the Railroad Retirement Board	10/01/2007
R120FM	Accounts Receivable Trending Analysis Procedures	07/02/2007
R83MCM	Chapter 11, Medicare Advantage Application Procedures and Contract Requirements	04/25/2007
R84MCM	Revisions to Chapter 12-Effect of Change of Ownership	04/25/2007

R81MCM	Updates to Chapter 1, General Provisions	N/A
R82MCM	Revision to Chapter 6 Relationships with Providers	N/A
R1227CP	Medicare Fee for Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan	05/23/2007

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