

Provider Partnership Program (PPP) E-mail Notification Archives

March 1, 2006

Hello everyone ~ just a few items to help get you through the week!

Attached is a new CMS fact sheet that addresses **Medicare Part D and homeless clients.**



homeless fact
sheet.pdf (235 K...

An updated **CMS Online Manual System brochure** has now been posted to the Medicare Learning Network's publications web page at

<http://www.cms.hhs.gov/MedlearnProducts/downloads/on-linebrochure.pdf>

This message, which was originally sent to you on Friday, February 24th, is being resent to include corrected language:

Level II HCPCS codes related to durable medical equipment, prosthetics, orthotics, and other supplies should be referred to the Statistical Analysis Durable Medical Equipment Regional Carriers (SADMERC), not the DMERCs (nor the DME MACs).

Do You Have a Hospital Outpatient Coding Question?

In a joint effort to improve billing and data quality, the American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) have joined together in establishing the AHA clearinghouse to handle coding questions on established Healthcare Common Procedure Coding System (HCPCS) usage. The American Health Information Management (AHIMA) will also provide input through the Editorial Advisory Board.

The clearinghouse will serve as a centralized point of contact to educate hospitals, policy makers and the public on HCPCS coding. Hospitals and health care professionals have experienced a growing need for greater consistency and improved understanding of HCPCS coding in the wake of implementation of prospective payment methods that utilize HCPCS coding for billing and payment purposes.

The AHA's Central Office will handle the clearinghouse functions and provide open access to any person or organization that has questions regarding a subset of HCPCS coding, particularly hospitals and other health professionals who bill under the hospital outpatient prospective payment system (OPPS). Inquiries on the application of level I HCPCS codes (CPT-4) for physicians will be referred to the American Medical Association. Level II HCPCS codes related to durable medical equipment, prosthetics, orthotics, and other supplies should be referred to the Statistical Analysis Durable Medical Equipment Regional

Carriers (SADMERC). The SADMERC is responsible for providing suppliers and manufacturers with assistance in determining which HCPCS code should be used to describe DMEPOS items for the purpose of billing Medicare. The SADMERC has a toll free helpline for this purpose, (877) 735-1326, which is operational during the hours of 9 AM to 4 PM (EST). In addition, the SADMERC publishes a product classification list on its website that lists individual items to code categories.

HCPCS-related questions must be submitted in the approved form, which you can download from the AHA website at <http://www.ahacentraloffice.org>, and either faxed or mailed directly to the AHA Central Office. Be advised that it is difficult to provide coding responses to generic scenarios without specific information. Refer to the form for additional information that should be submitted with your coding question(s).

The mailing address and fax number for HCPCS-related questions are as follows:

Central Office on HCPCS
American Hospital Association
One North Franklin
Chicago, IL 60606
Fax: 312-422-4583

Coding question information is also available at http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp on the CMS website.

For general HCPCS information, go to <http://www.cms.hhs.gov/MedHCPCSGenInfo/> on the CMS website.

Hope your week is going well ~ Valerie

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March 2, 2006

March is National Colorectal Cancer Awareness Month. As you know, colorectal cancer is the third most common type of cancer, and the second leading cause of cancer death. Like many other diseases, older adults are at greater risk for colorectal cancer. CMS wants to take this opportunity to remind health care professionals to encourage their Medicare patients ages 50 and older to get screened for colorectal cancer. Medicare covers colorectal cancer screening tests and procedures, specifically:

- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- Screening Colonoscopy
- Barium Enema

These screening tests can detect colorectal cancer early when it is most treatable, and can identify people at high risk for developing this type of cancer.

CMS needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For more information about Medicare's colorectal cancer screening benefit, including coverage, coding, billing, and reimbursement, refer to "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals" located at www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf on the CMS Medicare Learning Network (MLN) web page. In addition, CMS has issued Special Edition Medlearn Matters article SE0613 on colorectal cancer screening—click on the following link www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0613.pdf to review this article.

The CMS website also has a prevention website which contains a section on colorectal cancer screening. Click on www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention" to find the colorectal cancer screening section.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

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March 1 is here.... plan for new enrollees and plan switchers.

In the next few days, pharmacists will inevitably have to serve some Medicare beneficiaries who have enrolled in a plan or switched plans late in February. As a result, some of these beneficiaries may not yet be identified in pharmacy systems. As a reminder to pharmacists, we are once again sending instructions for using the eligibility (E1) functionality to check on plan

enrollment and Medicare eligibility status. Per-Se Technologies has issued recommendations for optimizing the E1. For more information you may visit their Medicare Part D home page, or contact your software vendor.

For beneficiaries who are eligible for both Medicare and Medicaid but who do not appear to have been enrolled in a plan, we are also sending instructions for using the Point of Sale Facilitated enrollment process. This process, known as the "Wellpoint Point of Sale solution", will allow pharmacies to submit claims to Wellpoint for a dual eligible beneficiary who does not appear to be enrolled in a plan so the beneficiary will not have to leave the pharmacy without the medications they need. A FAQ document and instructions can be found at Anthem Prescription's Medicare Part D home page.



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receiving DPMC.pdf..

March 3, 2006

The Centers for Medicare & Medicaid Services (CMS) will offer a final opportunity to receive training for the CAHPS® Hospital Survey (HCAHPS) in early April.

The CAHPS® Hospital Survey, also known as Hospital CAHPS or HCAHPS, was created to uniformly measure and publicly report patients' perspectives of their inpatient care. It is being implemented nationally as part of the work of the Hospital Quality Alliance (HQA), a partnership of federal agencies, hospital organizations, consumer and employer groups, clinicians, and other key national groups interested in quality measurement and public transparency. HCAHPS will provide a national standard and mechanism for collecting and reporting patient perspectives on care information and complement the efforts currently underway by many hospitals. A random sample of patients from each hospital will be asked to take the survey. And by having this information available on www.HospitalCompare.hhs.gov, consumers and others will be able to make more informed assessments of the hospitals serving their communities. Participation in HCAHPS is voluntary.

The first step toward implementation is to train those who will actually collect the patient responses. Survey vendors and those hospitals or health systems that wish to conduct HCAHPS on their own (without assistance from a survey vendor) must become familiar with the HCAHPS protocols. CMS will be providing one final opportunity to receive training for those hospitals and survey vendors that have not yet attended HCAHPS training. This training will cover all aspects of survey implementation and submission procedures. The dates for this training and information on how to register are provided below. Hospitals that are planning to participate in HCAHPS by using a survey vendor do not need to participate in the training, but should verify that their survey vendor will be participating. Training will be quickly followed by a short "dry run" of HCAHPS that will allow hospitals to gain first-hand experience using the survey -- without their results being publicly reported. All hospitals that intend to participate in HCAHPS in Fall 2006 must first take part in a dry run. Following the dry run, the HQA will begin implementation of HCAHPS for public reporting. Results from the first nine months of the survey will be publicly reported in late 2007.

Registration for HCAHPS Training

In order to participate in HCAHPS, vendors that administer the survey for their hospital clients, and hospitals that conduct the survey on their own, must attend the training. A hospital that engages a vendor to collect its HCAHPS data does not have to attend training, but its vendor must. To register on-line for training, please visit the HCAHPS web site at: www.hcahpsonline.org.

Vendors that administer HCAHPS for their hospital clients, and hospitals that conduct the survey on their own, who have not already received training must participate in two half-day, internet-based Webinar training sessions (April 3rd and 4th). No fees will be charged for training. Please note: *Training registration will close on March 24, 2006.*

Dry Run of HCAHPS

A short “dry run” of the survey will be implemented following training. The dry run will give hospitals/vendors first-hand experience in collecting and transmitting HCAHPS data -- without public reporting of results. Using the official survey instrument, approved survey modes, and data collection protocols, hospitals/vendors will collect HCAHPS data and report it to CMS. ***All hospitals that intend to participate in the national implementation of HCAHPS in Fall 2006 must take part in a dry run.***

National Implementation of HCAHPS

National implementation of the survey for public reporting purposes will follow the dry run. In its initial phase, HCAHPS data will be collected for nine months. Aggregate hospital results will be publicly reported in late 2007 on the Hospital Compare website, which can be found at www.hospitalcompare.hhs.gov, or through a link on www.medicare.gov. After this initial phase, HCAHPS data will be updated quarterly.

For Registration

To register for HCAHPS training, visit:

www.hcahpsonline.org

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In our continuing effort to communicate about implementation of the Medicare Prescription Drug Benefit, the Centers for Medicare and Medicaid Services (CMS) is pleased to announce the next Pharmaceutical, Pharmacy and Device Manufacturer Open Door Forum will be held on **March 7, 2006** and will focus exclusively on Medicare Part D implementation. The agenda follows:

- * Implementation Update
- * Plan/Pharmacy Process Workgroup
- * Outreach about late month plan enrollment and switching
- * Transitions, Exceptions & Appeals

Date: March 7, 2006

Start Time: 2:00 PM Eastern Standard Time (EST)

Conference Leader(s): Larry Kocot/Gil Kunken/Natalie Johnson

Dial: 1-800-837-1935, Reference Conference ID 4314785

To participate "in-person", an RSVP is required. To RSVP, please send an email by close of business (Friday, March 3) to PHARMACYODF-L@cms.hhs.gov. Persons participating by phone are not required 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.

MEDICARE DRUG COVERAGE PROVIDES SIGNIFICANT PRICE DISCOUNTS AND SAVINGS

Overview: Seniors and people with disabilities enrolled in Medicare prescription drug plans are seeing significant savings on the costs of their prescription drugs over what they would have paid with no drug coverage, according to a new report by the Centers for Medicare & Medicaid Services (CMS). Savings on many of the drugs that seniors take most often can be found through nearly all of the prescription drug plans included in the CMS analysis.

For more information, please see the attached CMS Fact Sheet.



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Also attached are the supporting charts for the Drug Pricing Analysis:



I hope you all have a great weekend ~ Valerie

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March 7, 2006

Susan Nedza, Medical Director of Region V CMS in Chicago, is participating in a Continuing Medical Education (CME) program for physicians sponsored by the Ohio State University **this coming Wednesday, March 8th, at 12:00 Noon (CST)**. Dr. Nedza will be going into detail about the Part D program and offering physicians information on how to streamline their dealings with the Part D Prescription Drug Benefit. If you want to participate in the program on Wednesday, the instructions for registration and log-on can be found at:

<http://ccme.osu.edu/cmeactivities/onlineeducation/webcast/>

The program will be archived for a year, so physician or other health care professionals who would like to get CME for this program can go to the above website.

Below are additional websites that we believe may be helpful to you in participating in the live program.

Here is the link to all OSU MedNet 21 programs:

<http://ccme.osu.edu/cmeactivities/onlineeducation/ondemand/osumednet21/>

Here is the link to a free Real Player (if needed):

http://forms.real.com/netzip/getrde6_new_look.html?h=207.188.7.150&f=windows/RealOnePlayerV2GOLD.exe&p=RealOne+Player&tagtype=ie&type=dl

Here is the link to a JAVA Script update (if needed):

http://www.java.com/en/download/windows_automatic.jsp

Viewers must create an account before viewing the program; it is advisable that you do that today (Tuesday) and that you also test with an on-demand program on Tuesday to make sure they are connecting properly. If you run into firewall issues, you need to consult your IS personnel to open things up. **CMS will start streaming at 11:30 CST**

(program starts at Noon) so live viewers can check their connectivity. If you want CME or ACPE educational credit, you will have to take the post-test.

Don't forget! CMS provides another CME course in conjunction with the University of Kansas, which you can link to from www.cms.hhs.gov/medlearn/drugcoverage.asp.

As always, we thank you for your continued efforts to help Medicare beneficiaries obtain this important benefit.

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March 8, 2006

Good afternoon everyone ~ I hope your week is going well so far. Attached are items alerting you that March is National Kidney Month and how you can use Medicare's covered preventive services to help identify and hopefully prevent kidney disease. I have also included information on NPI and phone scams related to Medicare Prescription Drug Coverage. I hope you find these items helpful!

March is National Kidney Month. As you know, chronic kidney disease (CKD) is a growing problem in the United States. CKD can lead to cardiovascular disease, among other serious health conditions, and left unchecked can eventually lead to kidney failure. Over 400,000 Americans suffer from kidney failure (end stage renal disease, or ESRD) and require either kidney dialysis or transplantation to live. Additionally, 8 to 20 million Americans have reduced kidney function, due primarily to diabetes and hypertension, which can lead to kidney failure. ESRD is Medicare's only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. Your patients may be at risk for chronic kidney disease if they:

- *Have Diabetes*
- *Have High Blood Pressure*
- *Have a Family History of Chronic Kidney Disease*
- *Are 60 Years of Age or Older*
- *Are from the following ethnic groups (African American, Hispanic, Asian or Pacific Islander)*

The Medicare Program provides coverage of kidney dialysis and kidney transplant services for eligible Medicare patients. Your Medicare patients may also be eligible for coverage of cardiovascular disease and diabetes screenings, diseases that may increase the risk of kidney damage.

What can you do? *Prevention is possible! Talk with your patients about their risk for kidney disease and encourage them to take advantage of the appropriate Medicare benefits, such as cardiovascular disease and diabetes screenings and medical nutrition therapy services. Early treatment can slow progression of kidney disease and reduce cardiovascular risk.*

Resources

To learn more about Medicare's coverage of and payment for kidney related services, please refer to the following publications, developed by the Medicare Learning Network (MLN) for health care professionals:

- *Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* www.cms.hhs.gov/MedlearnProducts/downloads/Book_Kidney_Dialysis-Final.pdf (Available in print or download)
- *Fistula First Breakthrough Initiative* www.cms.hhs.gov/MedlearnProducts/downloads/FistulaFirstbroch.pdf (Available in download only)
- *End Stage Renal Disease Composite Payment Rate System* www.cms.hhs.gov/MedlearnProducts/downloads/ESRDCompRatePaymentSys.pdf (Available in download only)
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf (Available in print or download)

Print products may be ordered, free of charge, from the MLN Product Ordering page located at www.cms.hhs.gov/medlearn on the CMS website. These products are also available to view on line as a download and may be reprinted or redistributed as needed.

Other Helpful Education Resources

- *National Kidney Disease Education Program* www.nkdep.nih.gov/ to learn more about kidney disease and how you can help your patients.

For more information about National Kidney Month visit www.kidney.org/ on the Web.

NPI Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

New Educational Products

CMS has released three new educational products on the National Provider Identifier (NPI):

Suitable for All Health Care Providers

- A Subparts Fact Sheet that contains high-level information on Medicare's guidance on subpart designation. Although the guidance is geared toward Medicare organization providers, non-Medicare organization providers may find it helpful.

- An Electronic File Interchange (EFI) Fact Sheet that contains basic information and links to helpful resources that will prepare providers and their staff for the release of the EFI system. This information is essential for organizations that wish to submit electronic files for bulk enumeration, and may be of interest to any health care provider for whom an organization will be submitting NPI application data.

Suitable for Medicare Providers

- A MLN Matters Article (SE0608) that takes a detailed look at Medicare's guidance on subpart designation and the impact on Medicare providers.

Visit the Educational Resources link at <http://www.cms.hhs.gov/NationalProviderStand/> to view these new products, as well as existing products such as: four *Medlearn Matters* articles, two fact sheets and the NPI Viewlet.

For more information on private industry NPI outreach, including upcoming meetings, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml> on the web.

Medicare Beneficiaries Urged to be on the Look-out for Phone Scams

The Centers for Medicare & Medicaid Services (CMS) warns seniors and people with disabilities to be aware of a scheme that asks Medicare beneficiaries for money and checking account information to help them enroll in a Medicare Prescription Drug Plan.

This scheme is called the “\$299 Ring” for the typical amount of money Medicare beneficiaries are talked into withdrawing from their checking accounts to pay for a non-existent prescription drug plan. Consumers can report these cases to their local law enforcement agencies or 1-877-7SAFERX (1-877-772-3379).

Please find the CMS Consumer Alert for your external distribution to find our more information on this alert.



\$299 phone scam.pdf (70 KB)

With best regards ~ Valerie

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March 9, 2006

Interested in seeing how well your county or state has done in providing colon cancer screening to people with Medicare? Click on the following link:

<http://www.mrnc.org/crcreport2/>

Medical Review of North Carolina, Inc., calculated national, state, and county colon cancer screening rates using Medicare claims data from 1998-2002. Almost 45% of those eligible for screening had at least one test in the five-year period. Other highlights from the data:

- Persons ages 65-74 comprised the largest eligible group (43%), but test use was highest among people ages 75-84 (50%);
- Test use was highest among Caucasians (46%) followed by Asians (40%), African Americans (36%), persons of Hispanic descent (36%) and Native Americans (28%);
- There was considerable disparity between the test rates for those eligible for only Medicare (47%) and persons eligible for both Medicare and Medicaid (35%);
- Persons eligible for Medicare due to a disability also had lower test rates (37%) than those eligible because of age (46%);
- Among the four covered tests, FOBT was the most commonly used test with a rate of 30%. Colonoscopy had the second highest use rate (23%), followed by sigmoidoscopy (12%) and barium enema (5%);
- Interval-based testing rates were much lower than the five-year Any CRC Test rate (30.7% compared to 44.9%).

What does all of this mean? Use of the Medicare covered colorectal cancer screening benefit has been low. Although no part of the Medicare population has high rates of test use, some groups are clearly at risk of not being tested, including people of racial and ethnic populations, the disabled, and those who have both Medicare and Medicaid.

What can you do? March is National Colorectal Cancer Awareness Month. Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their life.

For more information about Medicare's colorectal cancer screening benefit, including coverage, coding, billing, and reimbursement, refer to "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals" located at www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf on the CMS Medicare Learning Network (MLN) web page. In addition, CMS has issued Special Edition Medlearn Matters article SE0613 on colorectal cancer screening—click on the following link www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0613.pdf to review this article.

The CMS website also has a prevention website which contains a section on colorectal cancer screening. Click on cms.hhs.gov, select “Medicare”, and scroll down to “Prevention” to find the colorectal cancer screening section.

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March 10, 2006

Hello everyone ~ all I can say is thank goodness it's Friday!! For your reading pleasure I have included items on:

- *A Nursing Home Immunizations Toolkit;*
- *A Medicare Prescription Drug Update; and*
- *A Special Enrollment Period for Hurricane Katrina Evacuees.*

The Office of Clinical Standards and Quality (OCSQ) within the Centers for Medicare & Medicaid Services (CMS), in partnership with the Nursing Home Quality Improvement Organization Support Contractor (NH QIOSC) and Quality Partners of Rhode Island are pleased to announce the availability of a **Nursing Home Immunizations Toolkit**. This toolkit was developed with the help of numerous public and private partners participating in the Nursing Home Immunization Work Group of which CMS was a partner.

This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers. Printable resources include such products as:

- A Brochure
- Facility Sample Guidelines
- A Flyer
- Forms
- Posters
- A Staff News Letter
- Vaccination Sample Letters

The Immunizations Toolkit will be updated annually to reflect new information pertaining to influenza or pneumococcal disease or their respective vaccines. CMS is making this online resource available through the Medicare Quality Improvement Community (MedQIC) website. For more information on the Immunizations Toolkit visit

www.cms.hhs.gov/MedlearnProducts/35_PreventiveServices.asp#TopOfPage on the Medicare

Learning Network-Preventive Services webpage. We hope you find this a helpful tool as you plan for your resident and staff immunization program.

On Wednesday, March 8, 2006, HHS Secretary Mike Leavitt announced that the majority of states will no longer need to use their Medicaid systems to pay for **Medicare drug coverage**, a testament to the partnership between states and the federal government during the first weeks of the new drug coverage.

Forty-six states, plus the District of Columbia, were participating in the demonstration program designed to limit costs for Medicare beneficiaries who are also in Medicaid. Under the program, Medicare will reimburse states by reconciling drug payments with prescription drug plans, and by paying any differential between the drug plan reimbursement and Medicaid costs, and by paying state administrative costs. The program also outlines "best practices" on how to avoid the need for state billing systems.

Many of the states approved for the demonstration have either no claims or very few claims. Other states with significant Medicare populations -- South Carolina, Michigan, Indiana, Nebraska, and Iowa -- never submitted an application for the demonstration project. Other states did not activate their state payment systems, but have applied for relief of state administrative costs.

As of Wednesday, March 8, due to circumstances unique to each state, 12 states will continue to use their systems in limited instances for up to several more weeks. Many of these states have already substantially reduced their use of their state claims systems.

The states continuing in the program are: Arkansas, Arizona, California, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Texas, Vermont, and Wisconsin.

- Specifically, CMS has approved an extension of the demonstration for reimbursement of drug claims' costs until March 15, 2006 for Massachusetts and Wisconsin.
- CMS has approved an extension of the demonstration for reimbursement of drug claims' costs until March 17, 2006 for Arkansas.
- CMS has approved an extension of the demonstration for reimbursement of drug claims' costs until March 21, 2006 for New Hampshire.
- CMS has approved an extension of the demonstration for reimbursement of drug claims' costs until March 31, 2006 for the following states: Arizona, California, Maine, New Jersey, New York, Pennsylvania, Texas, and Vermont.

Medicare will continue to pay administrative costs through April 7, 2006 for all other states in the program, including the District of Columbia.

CMS will grant all **Hurricane Katrina evacuees a special enrollment period (SEP)** that gives them more time to change their Medicare prescription drug plans in 2006. Individuals will be

considered "evacuees" and eligible for this SEP if they reside in certain zip codes as identified by the Federal Emergency Management Agency at the time of the hurricane (August 2005). Please refer to the attached spreadsheet of designated zip codes.

The special enrollment period means that Katrina evacuees will be able to switch plans, including Medicare prescription drug plans, at any time through Dec. 31, 2006. This special enrollment period allows Katrina evacuees to change regardless of a change in residence, such as if they have temporarily located, have moved back to their permanent home, or if there are other circumstances that require more time to choose or change plans.

To determine if an individual is eligible for this SEP, Medicare plans must first attempt to obtain proof that the individual resided in an affected zip code (e.g., driver's license, utility bills, etc.). If the individual is unable to provide such proof, the plan must accept the beneficiary's attestation that he or she resided in an affected zip code.



KatrinaZips_SEP_3-7-06.xls (79...

Hope you get the opportunity to relax and enjoy your weekend!

With best regards ~ Valerie

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March 13, 2006

The next National Medicare & You Training Conference Call, sponsored by the Centers for Medicare & Medicaid Services, will be held:

- Friday, March 24, 2006
- 2:30-3:30 p.m. EST
- Featured topic is
"Coverage Determinations and Appeals under the Medicare Prescription Drug Program"

To connect to this conference call training:

- **Dial:** 1-800-988-9673 (please call in 15 minutes before session begins)
- **Enter pass code:** # 5247022
- **Call Leader:** Charlotte Newman

The PowerPoint Presentation will be available to view/download:

- Wednesday, March 22, 2006, after 3:00 p.m. EST
- On the CMS Partner Center website <http://www.cms.hhs.gov/center/partner.asp> under SPOTLIGHT.

This session will be recorded and available after March 30, 2006, at
<http://media.cms.hhs.gov/cms/partner03242006.wma>

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March 14, 2006

Prescribers are vital to the well being of their patients and the Centers for Medicare & Medicaid Services is doing everything we can to streamline the new Part D coverage to make it easier for you to help your patients, while not infringing on the scarce clinical time you have with them. The following link will take you to a video that we hope explains what we are doing during the transition to help prescribers and their office staffs smoothe the process of prior authorizations, exceptions and appeals. Go to our provider center at www.cms.hhs.gov/center/provider.asp (go to Part D tools) and select the video. There are a number of other useful lists that we have assembled there to help ease the process of helping your patients with their new drug coverage.

CMS has a dedicated email for prescriber's questions at PRIT@cms.hhs.gov, as well as a standing teleconference every Tuesday at 2PM by calling 1-800-619-2457 Passcode: RBDML

March 16, 2006

Hello everyone ~ another delivery of interesting information, including ~

- * *Medicare Preventive Services*
- * *FFS Expedited Determination Qs and As*
- * *Special ODF on Therapy Caps*
- * *Hospital IPPS*

March is National Colorectal Cancer Awareness Month, the optimal time to talk to your patients about screening. Research shows that a physician's recommendation is the most important factor in increasing the use of preventive and screening services. But the discussion can be complicated. Here are some links to information, resources, and tools to help physicians and other practitioners in communicating with their patients about colorectal cancer screening.

The American Cancer Society's website contains helpful information that clinicians can use to promote screening, including templates of letters that can be used to remind patients about colorectal cancer screening. The American Cancer Society and the National Colorectal Cancer Roundtable will also be releasing, "What You Should Know about Screening for Colorectal Cancer: A Primary Care Clinician's Evidence-Based Toolbox and Guide." This guide provides helpful tools and strategies that offices can implement to facilitate colorectal cancer screening. Links to these resources are provided below:

<http://www.cancer.org/colonmd/>
<http://www.nccrt.org>

The Centers for Disease Control and Prevention's website provides information about prevention and detection of colorectal cancer and materials that can be used to promote screening from the "Screen for Life" campaign. A link to this website is provided below:

<http://www.cdc.gov/colorectalcancer/>

The National Cancer Institute website provides information on prevention, detection, and treatment for colorectal cancer—here is a link to its website:

<http://www.cancer.gov/cancertopics/types/colon-and-rectal>

For more information about Medicare's colorectal cancer screening benefit, including coverage, coding, billing, and reimbursement, refer to "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals" located at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Medicare Learning Network (MLN) web page. In addition, CMS has issued Special Edition MLN Matters article SE0613 on colorectal cancer screening—click on the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf> to review this article.

The CMS website also has a prevention website which contains a section on colorectal cancer screening. Click on www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention" to find the colorectal cancer screening section.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their life.

A revised version of the **Fee-for-Service Expedited Determination Qs & As** have been posted to the FFS ED Notices portion of the BNI webpage (http://www.cms.hhs.gov/BNI/06_FFSEDNotices.asp#TopOfPage). Please scroll down to the Downloads section and click on the "Revised Expedited Determination Qs and As March 06 [PDF, 228kb]" link. These Qs & As target home health, hospice, CORF, and SNF providers.

SPECIAL OPEN DOOR FORUM:
Special Therapy Cap Exceptions Process
Monday, March 27, 2006
2:30 p.m. - 4:00 p.m. (Eastern Standard Time)

CMS announces a Special Open Door Forum on the Therapy Cap Exceptions Process. Policy Staff will identify what steps Medicare has taken to implement the new law related to Therapy Caps. Topics Include:

- * Eligibility for payment above the Cap
- * Beneficiary instructions for the approval process
- * Therapy Cap Exception Process Guidance on the CMS website

Conference Leaders: Dan Schwartz/Natalie Johnson

Open Door Participation Instructions:

CMS Staff and Authorized Speakers Only:

Dial: 1-877-792-5692

General Public

Dial: 1-800-837-1935

Reference Conference ID 6276237

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.

ADDRESS:

Hubert H. Humphrey Bldg.

Conference Room 425A

200 Independence Avenue S.W.

Washington, D.C. 20201

Map & Directions: <http://www.hhs.gov/about/hhhmap.html>

ENCORE: 1-800-642-1687; Conf. ID# 6276237

"Encore" is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID. beginning 2 hours after the call has ended. The recording will expire after 3 business days.

For Forum Schedule updates, Listserv registration and Frequently Asked Questions please visit our website at www.cms.hhs.gov/OpenDoorForums/ .

CMS will release the **Expanded Modified MEDPAR** at the same time the **Hospital Inpatient Prospective Payment System (IPPS)** proposed rule is available to the public. The anticipated display date of the IPPS proposed rule is currently April 6 with publication scheduled for April. The proposed rule Expanded Modified MEDPAR will use the December 2005 update of the FY 2005 MEDPAR. To expedite providing data during the IPPS comment period, we encourage interested parties to order the MEDPAR data now. We will process the orders in the order they are received beginning on the date the IPPS rule is available to the public. For information on how to order the Expanded Modified MEDPAR, go to the following web site:

<http://www.cms.hhs.gov/LimitedDataSets/> and click on MEDPAR Limited Data Set (LDS) - Hospital (National). This web page will describe the file and direct you to further detailed instructions for how to order. Please send the following: Letter of Request, LDS Data Use Agreement and Research Protocol(see website for further instructions), LDS Form and a check for \$3,655 to:

Centers for Medicare & Medicaid Services
Public Use Files
Accounting Division
P.O. Box 7520
Baltimore, MD 21207-0520

Hope you enjoy the rest of your week ~ Valerie

Valerie A. Hart, Director
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March 21, 2006

Please see the note below from the Centers for Medicare & Medicaid Services' (CMS) Program Integrity Group regarding an extension of the due date for comments concerning medically unbelievable edits.

Last week CMS informed providers that it would extend the due date for comments on medically unbelievable edits (MUEs) by at least 60 days. The revised due date is now June 19, 2006. However, this will not be the final opportunity for comment. Last week the Agency also announced that it is delaying implementation of the MUE effort to no earlier than January 1, 2007. This delay will allow the Agency to revisit the proposed MUEs based on the comments received during this first comment period, make necessary revisions, and then seek a second round of public comment this fall, prior to implementation in 2007.

CMS' intent for these edits is to prevent the payment of obviously erroneous Medicare claims submissions. The medically unbelievable edits are not meant as Medicare payment policy, but only to identify obvious billing mistakes. Throughout this effort CMS and its contractor, Correct Coding Solutions, LLC, will work closely with the provider community and have open discussions about the rationale and statistical basis for establishing these edits based on claims data. Further, CMS will consider the use of modifiers to allow for medically necessary services that may be clinical outliers and work

to develop an appeals process to allow for the reconsideration, as needed, of specific claims and specific MUEs.

CMS will continue to use its website and listservs to communicate information about this initiative as it progresses. We look forward to working proactively with the provider community to ensure our desired result of preventing improper Medicare payments.

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March 21, 2006

Great news, everyone! The Medicare Learning Network is pleased to announce a new name for its very popular Medicare fee-for-service provider education articles. Formerly known as "Medlearn Matters," these articles are now called "MLN Matters". We have changed the name to more closely associate these articles with the Medicare Learning Network, which is the official educational information source for Medicare fee-for-service providers. Please see the attached Special Edition article # SE0620 for details on this and other changes to the Medicare Learning Network's web pages.

I respectfully ask that you help us spread the word about this great news by distributing it to your membership, posting it on your website, and placing it in any of your publications.

As always, I very much appreciate your partnering efforts on our behalf.

With best regards ~ Valerie



SE0620.pdf (27 KB)

March 22, 2006

Under the Medicare prescription drug benefit, there is extra help available to beneficiaries with limited incomes and resources. This extra help provides comprehensive coverage with no or low premiums and low or no deductible. To ensure that beneficiaries receive the benefit of the extra help, CMS is facilitating the enrollment of certain beneficiaries into prescription drug plans. This week, CMS will begin mailing letters to approximately 1.2 million people who are enrolled in other federal assistance programs such as Supplemental Security Income (SSI) and Medicare Savings Programs, as well as beneficiaries who have applied for and been approved for the extra help.

The letters let the beneficiary know in which Medicare prescription drug plan they will be enrolled by CMS if they take no action before April 30. Unless they enroll on their own during March, these beneficiaries will have their prescription drug coverage begin on May 1. CMS is enrolling these beneficiaries earlier to make sure that they receive the benefit of the extra help immediately, and without having to pay a penalty. These beneficiaries can still decline the enrollment before it becomes effective.

All of the plans that qualify for the automatic enrollment must meet Medicare's standards for access to medically necessary drugs at a convenient local pharmacy. Beneficiaries also have the option to change plans if they are unhappy with the plan into which CMS facilitated them. The letters make it clear to beneficiaries that they can choose a different approved plan in their area. The facilitated enrollment letter will list all the prescription drug plans available in their region with premiums at or below the low-income premium subsidy amount. It also recommends calling 1-800-MEDICARE to find out more about these plans.

Attached is a fact sheet with more information about facilitated enrollment and copies of the facilitated enrollment letters. The fact sheet is also available on-line at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1806>. The letters will be posted on the CMS web site soon.



facilitated
enrollment final f...



11191 PARTIAL
3-07-06 w 34 bac...



11186 Full 3-07-06
w 34 back p...

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March 23, 2006

Have you talked with your patients about their risks for colorectal cancer and the benefits of screening? March is National Colorectal Cancer Awareness Month, the perfect time to discuss screening with your patients. Colorectal cancer is largely preventable through screening, which can find colon growths or polyps that can be removed before they turn into cancer. Screening can also detect cancer early when it is easier to treat and cure.

The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test that is used. An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Limiting screening to only these high-risk groups would miss the majority of colorectal cancers, thus screening is recommended for all adults ages 50 and older. In addition, risk for colorectal cancer increases with age; it is important to encourage patients who were screened before entering Medicare to continue with screening.

A variety of resources are available to help clinicians talk with patients about colorectal cancer screening:

The American Cancer Society website has tools for clinicians at the following website: http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp

The Cancer Research and Prevention Foundation website has “Tips for Healthcare Providers” which it compiled based on discussions with physicians, nurse practitioners, and physician assistants: <https://www.preventcancer.org/colorectal/facts/providers.cfm>

The National Cancer Institute website provides information on prevention, detection, and treatment for colorectal cancer—here is a link to its website:

<http://www.cancer.gov/cancertopics/types/colon-and-rectal>

For more information about Medicare’s colorectal cancer screening benefit, including coverage, coding, billing, and reimbursement, refer to “The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals” located at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Medicare Learning Network (MLN) web page. In addition, CMS has issued Special Edition MLN Matters article SE0613 on colorectal cancer screening—click on the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf> to review this article.

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Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their life.

Thank you.

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Reminder to Transition to ACC-NCDR ICD Registry by April 1, 2006

This is a reminder that in order to obtain payment, Medicare national coverage policy requires that providers implanting implantable cardioverter defibrillator (ICD) for primary prevention clinical indications (i.e., patients without a history of cardiac arrest or spontaneous arrhythmia) report data on each primary prevention ICD procedure. This policy became effective January 27, 2005. Details of the clinical indications that are covered by Medicare and their respective data reporting requirements are available in the Medicare National Coverage Determination (NCD) Manual, which is on the Centers for Medicare & Medicaid Services' (CMS) website at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf

On October 27, 2005, we announced that the American College of Cardiology National Cardiovascular Data Registry's (ACC-NCDR) ICD Registry™ satisfies Medicare's data reporting requirement for primary prevention ICD implantations. The ACC-NCDR ICD Registry™ will take the place of the ICD Abstraction Tool through QNet.

Hospitals will need to work with the ACC-NCDR directly in order to participate. Information is available on the web at <http://www.accncdr.com> or by telephone at 1-800-253-4636, ext. 451.

Hospitals that currently use the ICD Abstraction Tool through the Quality Network Exchange System (QNet) to report data on certain ICDs for Medicare beneficiaries are required to transition to the new registry. The ICD Abstraction Tool through QNet will no longer accept data beginning April 1, 2006. Therefore, all hospitals will need to have completed their transition to the ACC-NCDR ICD Registry™ by that date. In order to ensure that a complete and timely transition is made, hospitals should contact the ACC-NCDR immediately and should be enrolled with ACC-NCDR by April 1, 2006.

Reporting data for primary prevention ICD implants is a requirement of Medicare coverage. Without appropriately reported data, Medicare may be unable to approve your claims. We may also be required to take action to recoup payments already made if we discover data reporting discrepancies through our post-payment claims analysis.

We encourage you to review your facility's process for reporting ICD information to CMS to ensure that your facility's reports are filed timely and are consistent with the stipulations outlined in our national coverage determination (http://www.cms.hhs.gov/CoverageGenInfo/07_ICDregistry.asp#TopOfPage). By securing your staff's commitment to regular use of the ICD Registry, you will position your facility to comply with Medicare's ICD coverage policies.

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March 23, 2006

Two items in this note:

* Information about the next National *Medicare & You* Training Conference Call

* Correction to the Conference ID needed to access the Encore of the March 22, 2006 ESRD Clinical Labs Open Door Forum

The next National *Medicare & You* Training Conference Call, sponsored by the Centers for Medicare & Medicaid Services, will be held:

Friday, March 24, 2006

2:30-3:30 p.m. EST

Featured topic is "Coverage Determinations and Appeals under the Medicare Prescription Drug Program"

There are a limited number of call-in lines so please share access when possible.

To connect to this conference call training:

Dial: 1-800-988-9673 (please call in 15 minutes before session begins)

Enter pass code: # 5247022

Call Leader: Charlotte Newman

The PowerPoint slides can be downloaded NOW at the link below. Download **[2a]** under **Downloads**

http://www.cms.hhs.gov/NationalMedicareYouTrain/09_MedicareRxConferenceCalls.asp

The correct Conference ID to access the Encore (audio replay) of the March 22, 2006 ESRD Clinical Labs Open Door Forum is **6496126**.

ENCORE: 1-800-642-1687; Conf. ID# 6496126

"Encore" is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID., **beginning 2 hours after the call has ended**. The recording will be available for 3 business days.

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March 24, 2006

New MLN Matters Article Released re: Physician Voluntary Reporting Program

This is to notify you that several Physician Voluntary Reporting Program (PVRP) performance measure CPT codes that were in Change Request 4183 have been modified as a result of additional input received by CMS from medical specialty societies. In addition, CPT Category II codes are also now available for certain measures.

These changes are reflected in a new Change Request #5036. The attached **MLN Matters** article (MM 5036) contains the same information as **MLN Matters** article MM4183 **with the following additions:**

- Code changes and the addition of Category II CPT codes that are in the attachments contained within the article.
- An “Introduction” section that helps physicians understand 'who can report', and the benefits of registering their intent to participate in the program.
- Announcement of a web site address that contains additional information on the PVRP. This web address is <http://www.cms.hhs.gov/PVRP>. Also, in the “Additional Information” section of the article is a note about some helpful worksheets that will be placed on this site in the near future.

The article can also be accessed at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5036.pdf>

You can access Change Request 5036 at:

<http://www.cms.hhs.gov/transmittals/downloads/R43DEMO.pdf>

Mary K. Loane (for Valerie Hart)

March 30, 2006

Hello Everyone:

National Colorectal Cancer Awareness Month is over, but that doesn't mean the messages to your patients should stop until next year. Remind patients who have taken home a fecal occult blood test kit to use it. Follow up with patients on all screening results, even negative ones—everyone likes to hear good news.

Remember, the appropriate follow-up for a positive fecal occult blood test result is a colonoscopy, not another fecal occult blood test.

For more information about Medicare's colorectal cancer screening benefit, including coverage, coding, billing, and reimbursement, refer to "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals" located at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Medicare Learning Network (MLN) web page. In addition, CMS has issued Special Edition MLN Matters article SE0613 on colorectal cancer screening—click on the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf> to review this article.

The CMS website also has a prevention website which contains a section on colorectal cancer screening. Click on www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention" to find the colorectal cancer screening section.

Thank you for helping CMS spread the word regarding the importance of colorectal cancer screening. We are interested in knowing if the information we have provided over the last few weeks has been helpful and if it has influenced your colorectal cancer screening practices. Please e-mail us at: Prevention@cms.hhs.gov

Thank you.

Mary K. Loane (for Valerie Hart)
Centers for Medicare and Medicaid Services
Provider Communications Group
Division of Provider Information Planning and Development

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers has been updated and is now available online through the Medicare Learning Network's publication page located at,

www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf, on the CMS website. This comprehensive publication provides practical information on the types, uses, components of and standardized codes sets used on the RA as well as how to read the Standard Paper Remittance Advice and the Electronic Remittance Advice using PC-Print software (for institutional providers who receive RAs from Fiscal Intermediaries or

Regional Home Health Intermediaries) and Medicare Remit Easy Print software (for professional providers who receive RAs from Carriers or DMERCs). It also includes a number of helpful resources including field indexes (for institutional RAs and professional RAs), an acronym list, and a glossary. In addition to the online version of "The RA Guide", it will also be available in print and on CD ROM later this Spring. CMS will announce the availability of these products as they become available.

Mary K. Loane (for Valerie Hart)
Centers for Medicare & Medicaid Services
Provider Communications Group
Division of Provider Information Planning and Development

March 31, 2006

Transitional Toolkit

We are quickly coming to the end of the initial transition period for those people who signed up for the drug benefit in early January and February. The extended period ends on March 31, but for beneficiaries enrolling after these dates; the 30 day transition policy continues to apply. Hopefully, your patients have used this time to get a refill of their current drugs and have been working with you to get necessary exceptions to the plan's formulary. CMS is doing everything possible to encourage people with Medicare prescription drug coverage to work with their healthcare provider to get the medicines they need. The url referenced below contains several tools for your information, including a fact sheet that will help your office get to the right resources, a series of brochures that we have made available for beneficiaries, as well as a detailed explanation, including a power point presentation, about the exceptions and appeals process. This toolkit is available online at http://www.cms.hhs.gov/MLNProducts/downloads/transitional_toolkit.pdf on the CMS web.

New URL for MLN Drug Coverage Page

Please note that our URL is no longer <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>; our new URL is http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp on the CMS website.

Two New *MLN Matters* Articles

SE0614: "Access to the Part D Drug Benefit in Long Term Care Settings" - available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0614.pdf>

SE0619: "Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference" - available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0619.pdf>

Mary K. Loane (for Valerie Hart)