



CMS Medicare FFS Provider e-News *Brought to you by the Medicare Learning Network®*

CMS asks that you share the following important information with all of your association members and state and local chapters.

This issue of the e-News will be available in PDF format within 24 hours of its release in the [archive](#) with other past issues.

The e-News for Wednesday, August 22, 2012

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National Provider Call: Medicare Shared Savings Program Application Process Question and Answer Session — Register Now [[↑](#)]

Thursday, August 23; 1-2:30 pm ET

CMS subject matter experts will be available to answer questions about the Medicare Shared Savings Program (Shared Savings Program) and application process for the January 1, 2013 start date.

The [Shared Savings Program Application](#) web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application information and materials prior to the call.

Target Audience: All Medicare Fee-For-Service (FFS) providers and other interested stakeholders

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted prior to the call on the [FFS National Provider Calls](#) web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the [Continuing Education Credit Notification](#) web page to learn more.

National Provider Call: Audio Recording and Written Transcript from July 31 Medicare Shared Savings Program and Advance Payment Model Application Process Call Now Available [[↑](#)]

The audio recording and written transcript from the July 31 Medicare Shared Savings Program and Advance Payment Model Application Process National Provider Call are now available on the [July 31](#) call page in the “Presentation” section.

2012 Physician Quality Reporting System Program Reminder [[↑](#)]

It is not too late to start participating in the 2012 Physician Quality Reporting System (PQRS) and potentially qualify to receive an incentive payment equal to 0.5% of an eligible professional’s total Medicare Part B allowed charges for services furnished during the reporting period. A new six month reporting period using the registry submission option began on July 1, 2012. In addition, there are still ways to participate in the 12-month reporting period using claims, registry, or Electronic Health Record (EHR) submission.

The 2012 PQRS has two reporting periods: 12 months (January 1 through December 31, 2012) and 6 months (July 1 through December 31, 2012).

You can use one of the following options to report PQRS data for services furnished January 1 through December 31, 2012:

- EHR-based reporting (Direct EHR or Data Submission Vendor) of at least three PQRS measures for 80% or more of the applicable Medicare Part B FFS patients
- EHR-based reporting (Alignment with Medicare EHR Incentive Program) of all three Medicare EHR Incentive Program core measures OR up to 3 Medicare EHR Incentive Program alternate core measures AND 3 additional measures for the Medicare EHR Incentive Program
- Registry-based reporting of at least three PQRS measures for 80% or more of the applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 80% or more of applicable Medicare Part B FFS patients (with a minimum of 15 patients)
- Claims-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients

To report PQRS data for services furnished July 1 through December 31, 2012 use the following option:

- Registry-based reporting of one measures group for 80% or more of applicable Medicare Part B FFS patients (with a minimum of 8 patients)

Eligible professionals do not need to sign up or pre-register to participate in the 2012 PQRS. Submission of the appropriate quality data codes (QDCs) for individual PQRS measures or for a measures group to CMS on Part B claims will indicate intent to participate. Eligible professionals who intend to participate via registry or EHR mechanisms should work with their registry or EHR vendor on transmitting their 2012 PQRS measure data to CMS in early 2013.

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that eligible professionals should take prior to undertaking PQRS reporting. CMS has created many educational products that provide information about how to get started with PQRS reporting. To access all available educational resources on PQRS, please visit the [PQRS](#) website. Eligible professionals are encouraged to visit often for the latest PQRS-related information and downloads.

Eligible professionals also should note that 2012 is the last reporting year tied exclusively to an incentive payment. Beginning in 2015, CMS will apply a negative payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. Reporting during the 2013 PQRS program year will be used to determine whether a PQRS payment adjustment applies in 2015. The proposed criteria for satisfactorily reporting data on quality measures to avoid the 2015 PQRS payment adjustment is detailed in the [2013 Medicare Physician Fee Schedule Proposed Rule](#), which was published on July 30, 2012.

Resources:

- [2012 PQRS Implementation Guide and Measures List](#)
- [Phase 2 Qualified Registries for 2012 PQRS Reporting](#)
- [Final Qualified EHR Direct Vendors for 2012 PQRS Reporting](#)
- [Final Qualified EHR Data Submission Vendors for 2012 PQRS Reporting](#)
- [2013 Medicare Physician Fee Schedule Proposed Rule](#)

On Friday, August 17, CMS announced 17 sites selected to participate in the Community-based Care Transitions Program (CCTP). Together with the first 30 participants, the CCTP now includes 200 acute care hospitals partnering with community-based organizations (CBOs) across 47 sites to provide care transitions services for an estimated nearly 185,800 Medicare beneficiaries annually residing in 21 states.

The CCTP is a five-year program created by the Affordable Care Act. Participants sign two-year program agreements with CMS, with the option to renew each year for the remainder of the program, based on their success. As of the date of this announcement, CMS continues to accept applications and approve participants on a rolling basis as long as funds remain available.

Under the Affordable Care Act, the program may spend up to \$500 million over five years. With this round of agreements, CMS has committed over half of the \$500 million allocated to CCTP. The Innovation Center will continue to accept applications as long as funding is available.

For more information, visit the [Community-based Care Transitions Program](#) website.

CMS Announces Primary Care Practices to Participate in Historic Public-Private Partnership to Strengthen Primary Care [↑](#)

Seven Regions Will Test Unique Investment in Coordinated Care

In support of more effective, more affordable, higher quality health care, 500 primary care practices in seven regions have been selected to participate in a new partnership between payers from CMS, state Medicaid agencies, commercial health plans, self-insured businesses, and primary care providers. This partnership is designed to provide improved access to quality health care at lower costs.

Under the Comprehensive Primary Care Initiative, CMS will pay primary care practices a care management fee, initially set at an average of \$20 per beneficiary per month, to support enhanced, coordinated services on behalf of Medicare Fee-For-Service beneficiaries. Simultaneously, participating commercial, state, and other federal insurance plans are also offering enhanced payment to primary care practices that are designed to support them in providing high-quality primary care on behalf of their members.

For patients, this means these physicians may offer longer and more flexible hours, use electronic health records; coordinate care with patients' other health care providers; better engage patients and caregivers in managing their own care, and provide individualized, enhanced care for patients living with multiple chronic diseases and higher needs.

The initiative started in the fall of 2011 with CMS soliciting a diverse pool of commercial health plans, state Medicaid agencies, and self-insured businesses to work alongside Medicare to support comprehensive primary care. Public and private health plans in Arkansas, Colorado, New Jersey, Oregon, New York's Capital District-Hudson Valley region, Ohio and Kentucky's Cincinnati-Dayton region, and the Greater Tulsa region of Oklahoma signed letters of intent with CMS to participate in this initiative. The markets were selected in April, 2012 based on the percentage of the total population covered by payers who expressed interest in joining this partnership.

Eligible primary care practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012. Through a competitive application process, primary care practices within the selected markets were chosen to participate in the Comprehensive Primary Care

initiative. Practices were chosen based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by leading clinical societies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size, and ownership structure. CMS estimates that over 300,000 Medicare beneficiaries will be served by over 2,000 providers through this initiative.

The Comprehensive Primary Care initiative is a four-year initiative administered by the CMS Innovation Center. The CMS Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care.

For more information, please go to the [Comprehensive Primary Care Initiative](#) website.

Full text of this excerpted [CMS press release](#) (issued August 22).

People With Medicare Save Over \$4.1 Billion on Prescription Drugs Thanks to the Health Care Law [\[↑\]](#)

18 Million With Medicare Also Receive Free Preventive Services in the First Seven Months of 2012

As a result of the Affordable Care Act – the health care law enacted in 2010 – nearly 5.4 million seniors and people with disabilities have saved over \$4.1 billion on prescription drugs since the law was enacted, HHS Secretary Kathleen Sebelius announced on August 20. Seniors in the Medicare prescription drug coverage gap known as the “donut hole” have saved an average of \$768.

In addition, during the first seven months of 2012, the new health care law has helped nearly 18 million people with original Medicare get at least one preventive service at no cost to them.

The health care law includes benefits to make Medicare prescription drug coverage more affordable. In 2010, anyone with Medicare who hit the prescription drug donut hole received a \$250 rebate. In 2011, people with Medicare who hit the donut hole began receiving a 50% discount on covered brand-name drugs and a discount on generic drugs. These discounts and Medicare coverage gradually increase until 2020 when the donut hole is closed.

The health care law also makes it easier for people with Medicare to stay healthy. Prior to 2011, people with Medicare had to pay extra for many preventive health services. These costs made it difficult for people to get the health care they needed. For example, before the health care law passed, a person with Medicare could pay as much as \$160 for a colorectal cancer screening. Thanks to the Affordable Care Act, many preventive services are offered free of charge to beneficiaries, with no deductible or co-pay, so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.

In 2012 alone, 18 million people with traditional Medicare have received at least one preventive service at no cost to them. This includes 1.65 million who have taken advantage of the Annual Wellness Visit provided by the Affordable Care Act – over 500,000 more than had used this service by this point in the year in 2011. In 2011, an estimated 32.5 million people with traditional Medicare or Medicare Advantage received one or more preventive benefits free of charge.

- For [state-by-state information on savings in the donut hole](#)
- For [state-by-state information on utilization of free preventive services](#)

Full text of this excerpted [CMS press release](#) (issued August 20).

Long Term Care Hospital Technical Trainings related to the LTCH CARE Data Submission and LASER Available for Download [\[↑\]](#)

CMS wants to ensure that Long-Term Care Hospitals (LTCHs) are aware of the following technical trainings related to the LTCH Continuity Assessment Record and Evaluation (CARE) Data Submission and LTCH Assessment Submission Entry & Reporting (LASER) that are available for downloading on the [Quality Improvement and Evaluation System \(QIES\) Technical Support Office](#) website.

Data Submission Trainings:

- CMSNet and QIES User ID Registration Training – Recorded WebEx is now posted
- LTCH Assessment Submission Process – Recorded WebEx to be posted week of August 27
- LTCH Assessment and Validation Reports – Recorded WebEx to be posted week of August 27

The LASER trainings are as follows, and will also be available on QTSO.com:

- LASER Login Process – Recorded WebEx posted by the week of August 20
- LASER Patient and Assessment Entry – Recorded WebEx posted by the week of August 20
- LASER Import and Export Process – Recorded WebEx posted by the week of August 20
- LASER Reports – Recorded WebEx posted by the week of August 20
- LASER Demonstration Version of the tool posted by the week of August 20

Please note the following required information pertaining to the CMSNet and QIES User ID Registration Training Recorded WebEx LTCH User ID Registration Process:

- Effective August 20, LTCH providers required to submit LTCH CARE assessments for the LTCH Quality Reporting Program, may begin registering for their CMSNet and QIES User IDs. The CMSNet User ID allows users to access the CMS private Wide Area Network or WAN, where the LTCH CARE Submissions and CASPER Reporting systems reside. The QIES User ID allows users to submit LTCH CARE assessments to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. The QIES User ID also allows users to access the assessment and submission reports in the CASPER Reporting application for LTCH CARE assessments that were submitted. The CMSNet and QIES User IDs are not used for submission of Healthcare-Associated Infection (HAI) data to the Centers for Disease Control (CDC).
- Each provider will be allowed two CMSNet User IDs and two QIES User IDs. LTCH providers will be required to request the CMSNet user IDs first, followed by an online registration process for the QIES User ID.
- The LTCH Provider User Registration WebEx training session, which is available on the QTSO website, provides the necessary information for the User ID registration processes. The training session must be reviewed prior to attempting the registration process.
- It is important that the User ID registration processes be completed by September 14, 2012 to ensure that the necessary User IDs are available and activated prior to the October 1, 2012 LTCH CARE assessment submission requirement.
- See the essential information about the LTCH Provider User Registration WebEx training session, below.

LTCH Provider User Registration Training WebEx Posted August 2012

The LTCH Provider User ID Registration training recording is available for viewing. This recording demonstrates the processes for requesting a CMSNet User ID and a Quality Improvement and Evaluation System (QIES) User ID that are required to submit LTCH CARE assessment data to the QIES ASAP system.

Individuals from providers responsible for submitting LTCH CARE assessment data beginning October 1, 2012, must view this training. These individuals are required to have two separate user IDs (a CMSNet User ID and a QIES User ID), which will allow access to submit LTCH CARE assessments and review pertinent assessment and submission reports.

To access the training WebEx, follow these steps:

- Access the [QTSO e-University page](#)
- Select the “Other” link located in the Recorded Training Sessions Categories box and the QTSO e-University login page will display.
- Enter your first and last name and email address in the “Name” and “Email” fields.
- Select the “Go” button and the Recorded Training Sessions page will display.
- Select the “Provider User ID Registration Processes” link from the Recorded Training Sessions box to view the recording.

Important notes:

- The file format for this recording is Windows Media Video (WMV). Windows Media Player is recommended for viewing.
- This training session contains audio and visual information. Ensure your computer speakers are turned on to hear the audio.
- This recorded training session contains closed captioning. Select the “Closed Captioning Instructions” link in the Recorded Training Sessions box to access instructions for enabling the closed captioning feature, if needed.
- Please contact the QTSO Help Desk by phone, at 877-201-4721, or by email at help@qtso.com if you have questions regarding this training session.

Develop Your ICD-10 Communication and Awareness Plan [\[↑\]](#)

Although the final rule on the proposed ICD-10 deadline change has not yet been published, it's important to continue planning for the transition to ICD-10. A critical step in planning is to build organizational awareness and to develop a communication plan.

A communication and awareness plan ensures that all your employees and other internal departments as well as external business partners understand their roles and responsibilities for ICD-10 implementation. Think of this communication plan as a formal roadmap for communicating about ICD-10 throughout the transition. A plan is particularly important in larger organizations where you work with many different people and departments that may affect your successful transition to ICD-10. But it can be just as important in a small practice that everyone knows what, why, and how the transition will happen.

Your communication plan should identify:

- Project purpose – Provide ICD-10 background information and clearly describe the current state of ICD-10 progress in your organization, identify goals for the communication and awareness plan, and explain the purpose and expected outcomes of the transition.
- Partners – Identify all parties involved in your ICD-10 transition. For internal staff, you will need to establish a process to communicate governance issues to leaders and assess staff training needs. Coordinate with external groups such as vendors, clearinghouses, and state agencies about implementation updates and changes required in your systems and business processes.
- Messages – Be clear and consistent about what you say, focusing on specific steps and actions that need to happen for the ICD-10 transition.
- Issues – Outline your organization's protocol for identifying potential implementation issues and provide a plan for correcting them.
- Roles and responsibilities – Assign and clearly define communication roles and responsibilities to everyone involved in the transition.

- Timelines – Identify project milestones, secondary tasks, and deadlines. Be certain all project teams know what they will need to do. Develop back-up plans for each milestone to help you handle potential problems.
- Communication methods – Think about how to best communicate within your organization. Emails, in-person meetings, and conference calls may all be effective, but some might work better for different staff and divisions.

While the size of your organization will determine how much planning and documentation will be necessary for the ICD-10 transition, it is always important to keep the lines of communication open. This will help to foster trust among staff members and show that your organization is taking steps to implement ICD-10.

Keep Up to Date on ICD-10:

Please visit the [ICD-10](#) website for the latest news and resources to help you prepare.

Act Now to Avoid Claim Denials for Ordered/Referred Services [\[↑\]](#)

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60-day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

If you order or refer items or services for Medicare beneficiaries, or bill for these services, please read these CMS resources to be sure you are following Medicare requirements.

MLN Matters® Articles:

- [#SE1221 Phase 2 of Ordering and Referring Requirement](#)
- [#SE1011 Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims](#)

MLN Fact Sheets:

- [“Medicare Enrollment Guidelines for Ordering/Referring Providers”](#)
- [“The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement”](#)

All providers may also confirm whether or not an eligible ordering or referring provider is enrolled in Medicare by reviewing the [Ordering and Referring File](#) on the CMS website.

All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer [\[↑\]](#)

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862(a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-*

588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.

For more information about provider enrollment revalidation, review the Medicare Learning Network's [Special Edition Article #SE1126](#), titled "Further Details on the Revalidation of Provider Enrollment Information."

CY 2012 Home Health Prospective Payment System PC Pricer has been Updated [\[↑\]](#)

The CY 2012 Home Health (HH) Prospective Payment System (PPS) PC Pricer data has been updated with July 2012 provider data and is now available on the [HH PPS PC Pricer](#) web page in the "Downloads" section. A change to correctly display the LUPA add on was also made.

Inpatient Prospective Payment System PC Pricer Updated [\[↑\]](#)

The FY 2012 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with the latest Provider Data. The latest version is now available on the [Inpatient PPS PC Pricer](#) web page in the "Downloads" section. This PC Pricer is for claims dated from October 1, 2011 to September 30, 2012.

January 2013 Edit Spreadsheet Changes [\[↑\]](#)

CMS is updating the implementation date of certain 837P and 837I edits. The following 5010 837P and 837I transaction edits are being implemented within the next 30 days:

X222 Edits	X223 Edits
X222.114.2000B.HL04.015	X223.107.2000B.HL04.020
X222.116.2000B.SBR04.005	X223.109.2000B.SBR04.004
X222.116.2000B.SBR04.007	X223.109.2000B.SBR04.007
X222.076.1000A.PER04.070	X223.319.2310A.NM109.005
X222.076.1000A.PER06.070	X223.073.1000A.PER04.070
X222.076.1000A.PER08.070	X223.073.1000A.PER06.070
X222.098.2010AA.PER04.070	X223.073.1000A.PER08.070
X222.098.2010AA.PER06.060	X223.091.2010AA.PER04.070
X222.098.2010AA.PER08.060	X223.091.2010AA.PER06.060
X222.131.2010BA.PER04.070	X223.091.2010AA.PER08.060
X222.277.2310C.PER04.060	
X222.462.2420E.PER04.070	
X222.462.2420E.PER06.070	

The edit spreadsheets for these edits and prior versions of the 837P and 837I edit spreadsheets can be found on the [5010 - D.0 Technical Documentation](#) web page.

August 2012 Version of Medicare Learning Network® Products Catalog Now Available [\[↑\]](#)

The August 2012 version of the [MLN Products Catalog](#) is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on “Formats Available.”

“Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)” MLN Matters® Article — Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1230](#), “Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)” was released and is now available in downloadable format. This article is designed to provide education on a new feature to Internet-based PECOS that allows providers to digitally upload supporting documents and submit them electronically with their enrollment application. It includes an overview of the new feature and a link to the “Digital Documents Repository How to Guide” for additional information on how to use it.

New Enhancements to the MLN Product Ordering System [\[↑\]](#)

The Medicare Learning Network® (MLN) Product Ordering System was recently upgraded to add new enhancements. You can now view an image of the product and access its downloadable version, if available, before placing your order. To access a new or revised product available for order in *hard copy* format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.

New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses [\[↑\]](#)

The MLN is happy to announce that the latest continuing education association to accept MLN courses is the Healthcare Billing & Management Association (HBMA). HBMA joins the AAPC, American Association of Medical Assistants (AAMA), the American Association of Medical Audit Specialists (AAMAS), the American Medical Billing Association (AMBA), the Medical Association of Billers (MAB), and the National Academy of Ambulance Coding (NAAC).

For more information about continuing education associations that accept MLN courses, visit the [Association Approvals for WBT Credits](#) web page on the CMS website. If the association you belong to accepts outside credit sources and is not on the list, you should contact them to see if they are interested in working with the MLN. If they are interested, the association should e-mail CE_Issues@cms.hhs.gov.

From the MLN: “CMS Website Wheel” Educational Tool — Reminder [\[↑\]](#)

The “CMS Website Wheel” Educational Tool (ICN 006212) is now available in hard copy format. This educational tool is designed to provide education on a variety of CMS Medicare-related website addresses. It includes URLs listed by topic.

To access a product available for order in hard copy format, go to [MLN Products](#) and under “Related Links” click on the “MLN Product Ordering Page” at the bottom of the web page.

From the MLN: “Medicaid Program Integrity: Safeguarding Your Medical Identity” Educational Products — Released [\[↑\]](#)

In an effort to expand and offer national educational products on a variety of topics that affect both Medicare and Medicaid providers, the Medicare Learning Network® (MLN) has released a [new package of products related to Medicaid Program Integrity and medical identity](#). The following products are designed to educate both Medicare and Medicaid providers about medical identity theft and strategies for addressing it:

- [Safeguarding Your Medical Identity](#): This web-based training course (WBT) is designed to provide education on medical identity theft. It includes information on how to recognize risks and resources that Medicare and Medicaid providers can use to protect their medical identity. Continuing education credits are available to learners who successfully complete this course. See course description for more information. To access the WBT, go to [MLN Products](#), and click on “Web-Based Training Courses” under “Related Links” at the bottom of the web page.
- [Medicaid Program Integrity: Understanding Provider Medical Identity Theft](#): This booklet is designed to provide education on the scope and definition of medical identity theft. It includes information on cases involving stolen provider medical identities and strategies that Medicare and Medicaid providers can use to protect themselves against medical identity theft.
- [Medicaid Program Integrity: Preventing Provider Medical Identity Theft](#): This fact sheet is designed to provide education on how to prevent provider medical identity theft. It includes information on actions Medicare and Medicaid providers can take to mitigate potential risks to their medical identity.
- [Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education \(CME\)](#): This educational tool is designed to provide a list of websites and other resources related to Medicare and Medicaid medical identity theft.

More helpful links...

Check out CMS on:



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