



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.

Colleagues—

It's easier than ever to access Medicare Learning Network® educational information. Products, articles, national calls, the e-News, and more....the MLN is your official source for CMS education and information for Medicare Fee-For-Service Providers. Links to all MLN resources are conveniently located on the new [MLN General Information web page](#).

Download the free [MLN button](#) — a direct link to the MLN General Information page — onto your selected web pages so that members and/or staff have information at their fingertips.

Thank you for helping us get the word out about the Medicare Learning Network®.

— Robin

The e-News for Wednesday, September 5, 2012

NATIONAL PROVIDER CALLS

- [Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Register Now](#)

ANNOUNCEMENTS AND REMINDERS

- [September is National Cholesterol Education Month](#)
- [Influenza Season is Around the Corner](#)
- [Registration Reminder for DMEPOS Competitive Bidding](#)
- [Medicare Part B Outpatient Therapy Cap and Exceptions Process Extended Through December 31, 2012](#)
- [Reporting Clinical Quality Measures Will Change for All Providers in 2014](#)
- [Find out How the Stage 2 Rule Affects Medicaid EHR Incentive Program Participants](#)
- [New CMS Resource Available: Payment Adjustment & Hardship Exceptions Tipsheets for Eligible Hospitals and Eligible Professionals](#)

- [New Comparison Tables Highlight the Differences Between the Two Stages of Meaningful Use](#)
- [Medscape Modules Available on ICD-10](#)
- [Now Available: New Email Updates for Those Who Refer Medicare Beneficiaries for DMEPOS](#)

MLN EDUCATIONAL PRODUCTS UPDATE

- [“Medicare Claim Submission Guidelines” Fact Sheet — Revised](#)
- [Medicare Learning Network® Exhibit Schedule](#)

National Provider Call: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Register Now [[↑](#)]

Thursday, September 13, -2-3:30pm ET

On August 23, CMS announced the final rule for Stage 2 requirements and other changes to the EHR Incentive Programs. This National Provider Call will provide an overview of the final rule, so you can learn what you need to know to receive EHR incentive payments.

The final rule can be found at [CMS Stage 2 Final Rule](#). For more information on the EHR Incentive Programs, visit the CMS [EHR Incentive Programs](#) website.

Target Audience: Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details:

- [Eligibility Requirements for Professionals](#)
- [Eligibility Requirements for Hospitals](#)

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs

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.

September is National Cholesterol Education Month [\[↑\]](#)

National Cholesterol Education Month is a good time to help your Medicare patients get their blood cholesterol level checked and take steps to lower it if it is high. High blood cholesterol affects over 65 million Americans. It is a serious condition that can increase your patients' risk for heart disease. Medicare provides coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke. These tests can help determine a beneficiary's cholesterol and other blood lipid levels.

Medicare Coverage:

Medicare provides coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries once every 5 years. The beneficiary must have no apparent signs or symptoms of cardiovascular disease. Covered screening tests include:

- Total Cholesterol Test
- Cholesterol Test for High-density Lipoproteins
- Triglycerides Test

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit). Encourage your eligible Medicare patients to take advantage of this screening benefit.

Important Note: The cardiovascular screening benefit covered by Medicare is a standalone billable service separate from the Initial Preventive Physical Examination (also known as the "Welcome to Medicare" preventive visit) and the Annual Wellness Visit.

For More Information:

- [The Guide to Medicare Preventive Services for Healthcare Professionals](#), Chapter 3
- [Medicare Preventive Services Quick Reference Information Chart](#)
- [Expanded Benefits Brochure](#)
- [National Heart, Lung, and Blood Institute – National Cholesterol Education Month website](#)
- [Million Hearts Website](#)

Influenza Season is Around the Corner [\[↑\]](#)

As your patients age, their immune systems may weaken. This weakening can make seniors more susceptible to complications from seasonal influenza (flu). Now is the perfect time to remind your patients that seasonal influenza vaccination is the best defense against the flu. Medicare provides coverage for one flu vaccine and its administration per influenza season for seniors and other Medicare beneficiaries with no co-pay or deductible. Talk with your Medicare patients about their risk for getting the flu and start protecting your patients as soon as your 2012-2013 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff. *Know what to do about the flu.*

Remember – Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug. CMS will provide information and a link to the 2012-2013 Influenza Vaccine prices when they are available.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit the [CMS Medicare Learning Network Preventive Services Educational Products](#) and [CMS Immunizations](#) web pages. And, while some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu vaccines.

Registration Reminder for DMEPOS Competitive Bidding [[↑](#)]

We would like to remind all suppliers interested in participating in the Round 1 Reopen of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program that registration for user IDs and passwords is open. If you are interested in bidding, you must designate one authorized official (AO) from those listed on the CMS-855S enrollment form to act as your AO for registration purposes, and that AO must register.

We strongly urge all AOs to register no later than September 7, 2012, to ensure that AOs have time to designate other supplier employees to use the online DMEPOS Bidding System (DBidS).

When bidding opens, suppliers will need to submit their bids using DBidS. To help ensure bid security and privacy, suppliers interested in bidding must first register all employees who will enter information in DBidS to obtain a user ID and password through the Individuals Authorized Access to CMS Computer Services (IACS) system. Only supplier employees who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as backup authorized officials (BAOs). The AO and BAOs can designate other supplier employees as end users (EUs). BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the National Supplier Clearinghouse (NSC) to register successfully.

Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name and SSN does not match what is on file with the NSC. We recommend that BAOs register no later than *September 28, 2012*, so that they will be able to assist AOs with approving EU registration.

Registration will close on *Friday, October 19, 2012 at 9pm* prevailing Eastern Time – *no AOs, BAOs, or EUs can register after registration closes.*

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, www.dmecompetitivebid.com, click on *Round 1 Reopen*, and then click on "REGISTRATION IS OPEN" above the Registration clock. Before you register, we strongly recommend that you review the [IACS Reference Guide](#) with step-by-step instructions and the [Getting Started Registration Checklist](#).

If you have any questions about the registration process, please contact the CBIC Customer Service Center at 877-577-5331 between 9am

and 9pm prevailing Eastern Time, Monday through Friday.

*The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for “Email Updates” on the home page of the CBIC website. For information about the Round 1 Recompete, please refer to the bidder education materials on the CBIC website located under *Round 1 Recompete > Bidding Suppliers*.*

Medicare Part B Outpatient Therapy Cap and Exceptions Process Extended Through December 31, 2012 [\[↑\]](#)

The Middle Class Tax Relief and Job Creation Act of 2012 (H.R.3630) was signed into law on February 22, 2012; extending the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2012.

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is \$1,880 for 2012, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also \$1,880 for 2012. This is the annual per beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of \$3,700 for PT and SLP services combined and another threshold of \$3,700 for OT services. All therapy services rendered above the \$3,700 are subject to manual medical review and certain providers will be required to submit a request for an exception.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private practices
- Part B skilled nursing facilities
- Home health agencies (TOB 34X)
- Outpatient rehabilitation facilities (ORFs)
- Rehabilitation agencies (Comprehensive Outpatient Rehabilitation Facilities-CORFs)
- Hospital outpatient departments (HOPDs) – beginning October 1, 2012 until December 31, 2012

The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning on October 1, 2012 some therapy providers will be required to submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the \$3,700 threshold). The \$3,700 figure is the defined threshold which triggers the requirement for an exception request. This requirement will not be imposed on all therapy providers at one time, it will be phased in, and therapy providers will be assigned to three groups or phases. The requirement to submit an exception request will be imposed on them on the dates listed below depending on which of the three groups or phases to which they are assigned.

- Phase I October 1 to December 31, 2012
- Phase II November 1 to December 31, 2012
- Phase III December 1 to December 31, 2012

If you are a provider of physical therapy, speech-language pathology services, or occupational therapy services, you may receive a letter titled “Notification of Request for Exception Requirements for Therapy”, indicating your assigned phase.

You can find your assigned phase [here](#). If you do not find your NPI number on the list, then you are in Phase III.

If you have questions, please contact your local Medicare Administrative Contractor's (MAC's) Customer Service Department. You can find your local MAC on the [Provider Compliance Interactive map](#).

For more information on the Medicare Part B outpatient therapy cap and exceptions process visit the Medical Review and Education [website](#).

Reporting Clinical Quality Measures Will Change for All Providers in 2014 [\[↑\]](#)

On August 23, CMS announced the final rule for Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule provides new criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet to successfully participate in the EHR Incentive Programs.

The final Stage 2 rule establishes that beginning in 2014, the reporting of clinical quality measures (CQMs) will change for *all* providers, regardless of whether they are participating in Stage 1 or Stage 2. EHR technology certified to the 2014 standards and capabilities will contain new CQM criteria.

In 2014, EPs, eligible hospitals, and CAHs in both Stage 1 and Stage 2 of the EHR Incentive Programs must use the new criteria. All providers must report on CQMs to demonstrate meaningful use, even though CQM reporting was removed as a core objective.

Provider	Before 2014	2014 and Beyond
EPs	Complete 6 out of 44 CQMs <ul style="list-style-type: none"> • 3 core or 3 alternate core • 3 menu Selected CQMs must cover at least 3 of the National Quality Strategy (NQS) domains	Complete 9 out of 64 CQMs Choose at least 1 measure in 3 NQS domains Recommended core CQMs include: <ul style="list-style-type: none"> • 9 CQMs for the adult population • 9 CQMs for the pediatric population • Prioritize NQS domains
Eligible Hospitals and CAHs	Complete 15 out of 15	Complete 16 out of 29 <ul style="list-style-type: none"> • Choose at least 1 measure in 3 NQS domains

Reporting CQMs in 2014 and Beyond

- All Medicare-eligible providers in their second year and beyond of demonstrating meaningful use must electronically report CQM data to CMS, starting in 2014
- Medicaid providers will electronically report CQM data to their state

CQM Tipsheet

CMS has published a [tipsheet](#) that includes more information on the CQM 2014 changes.

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates.

Find out How the Stage 2 Rule Affects Medicaid EHR Incentive Program Participants [\[↑\]](#)

On August 23, CMS announced the final rule for Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule provides new criteria that eligible professionals (EPs) and eligible hospitals must meet in order to successfully participate in the EHR Incentive Programs.

Included in the Stage 2 final rule are important changes to the Medicaid EHR Incentive Program, including the determination of patient volume calculations. Importantly, the changes to Medicaid patient volume calculations are applicable to eligible providers regardless of which stage of the EHR Incentive Program they are participating in. It is important for Medicaid providers that they understand these changes and how they affect their participation in the program.

Click on the links below for information about:

Medicaid changes to patient volume calculations

Q: The Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?

A: Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume threshold, regardless of Medicaid's payment liability for the services, and irrespective of whether the provider is in Stage 1 or Stage 2 of the incentive program. [Read the rest of the answer here.](#)

CHIP patients eligible to be included in Medicaid patient volume totals

Q: The Stage 2 Rule describes changes to how a state considers CHIP patients in the Medicaid patient volume total when determining provider eligibility. Patients in which kinds of CHIP programs are now appropriate to be considered in the Medicaid patient volume total?

A: States that have offered CHIP as part of a Medicaid expansion under Title 19 or Title 21 can include those patients in their provider's Medicaid patient volume calculation as there is cost liability to the Medicaid program in either case (in Stage 1, only CHIP programs created under a Medicaid expansion via Title 19 were eligible). This change to the patient volume calculation is applicable to all eligible providers, regardless of the stage of the incentive program they are participating in. [Read the rest of the answer here.](#)

Changes to the base year of the Medicaid EHR Incentive Program for hospital incentive payment calculation

Q: Are there any changes to the base year for the Medicaid EHR Incentive Program hospital incentive payment calculation?

A: Yes, but depending on when a hospital starts participating in the incentive program. Under the Stage 1 Rule, all Medicaid eligible hospitals calculated the base year using a 12-month period ending in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. But as described in the Stage 2 rule, hospitals that begin participating in the incentive program in program year 2013 or later will use the most recent continuous 12-month period for which data are available prior to the payment year. [Read the rest of the answer here.](#)

To find out more information about the Stage 2 final rule, visit the [Stage 2 section](#) of the EHR website.

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates.

New CMS Resource Available: Payment Adjustment & Hardship Exceptions Tipsheets for Eligible Hospitals and Eligible Professionals [[↑](#)]

CMS has developed new tipsheets to help providers learn more about congressionally mandated payment adjustments that will be applied to Medicare eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that do not demonstrate meaningful use of certified electronic health record (EHR) technology under the EHR Incentive Programs.

Click [here](#) to download the tipsheet for EPs and [here](#) for the tipsheet for eligible hospitals and CAHs.

Key takeaways from the tipsheets include:

Medicare EPs

- Payment Adjustment Amount: 1% per year, cumulative for every year that an EP is not a meaningful user. The maximum cumulative payment adjustment is 5%.
- Timing: Payment adjustments begin on January 1, 2015.

Medicare Subsection (d) Eligible Hospitals

- Payment Adjustment Amount: Applicable to the percentage increase to the Inpatient Prospective Payment System (IPPS) rate. Hospitals that do not demonstrate meaningful use will receive a lower payment than the IPPS standard amount. The payment adjustment is cumulative for each year that a Medicare Subsection (d) eligible hospital does not demonstrate meaningful use.
- Timing: Payment adjustments begin on October 1, 2014.

Critical Access Hospitals

- Payment Adjustment Amount: This payment adjustment for CAHs applies to their Medicare reimbursement for inpatient services during the cost reporting period in which they did not demonstrate meaningful use. If a CAH has not demonstrated meaningful use, its reimbursement would be reduced from 101% of its reasonable costs to 100.66%.
- Timing: Payment adjustments will begin with the fiscal year 2015 cost reporting period.

Hardship Exceptions

Hardship exceptions will be granted to EPs, eligible hospitals and CAHs only under specific circumstances. Providers must demonstrate to CMS

that those circumstances pose a significant barrier to achieving meaningful use. Information on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website in the future.

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates.

New Comparison Tables Highlight the Differences Between the Two Stages of Meaningful Use [\[↑\]](#)

On August 23, CMS announced the final rule for Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule provides new criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet to successfully participate in the EHR Incentive Programs.

Stage 1 vs. Stage 2 Tables

CMS created Stage 1 vs. Stage 2 Comparison Tables to help providers navigate the next Stage of meaningful use. There is a table for both [EPs](#) and for [eligible hospitals and CAHs](#), and each compares the Stage 1 and Stage 2 core and menu objectives. Providers will be able to see which measures are new, which ones are changing, and which ones are being removed. The tables can be found online in the [Stage 2 section](#) of the CMS EHR Incentive Programs website.

Snapshot of the Comparison Tables

The table below is a small snapshot of the EP comparison table that is available online. Visit the Stage 2 section of the website to view the complete tables.

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 Clinical Decision Support measure</i>
Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Generate and transmit permissible prescriptions electronically (eRx)	More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates.

Medscape Modules Available on ICD-10 [[↑](#)]

CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. Continuing medical education (CME) credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion.

The modules are free. You can use the links below to access them. If you are not a member of Medscape, you will first be prompted to fill out a brief registration form.

The videos, [ICD-10: A Guide for Small and Medium Practices](#) and [ICD-10: A Guide for Large Practices](#), feature Daniel J. Duvall, MD, MBA, medical officer with the Hospital and Ambulatory Policy Group at CMS, describe:

- Global differences between ICD-9 and ICD-10
- How ICD-10 will have different impacts on practices of different sizes
- Basic transition planning steps and resources

In the article [Transition to ICD-10: Getting Started](#), Joseph Nichols, MD, of Health Data Consulting covers documentation improvements, the coder-clinician relationship, training, working with vendors and payers, search tools, and resources.

For questions or technical assistance with the CME modules, please contact Medscape at CME@medscape.net.

Keep Up to Date on ICD-10

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

Now Available: New Email Updates for Those Who Refer Medicare Beneficiaries for DMEPOS [[↑](#)]

The Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (The Program) was successfully implemented in nine areas on January 1, 2011. Round 2 of The Program is targeted to go into effect in 91 metropolitan statistical areas (MSAs) on July 1, 2013. See the [Locations](#) and [Products](#) that will be affected by the second round of competitive bidding. CMS will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

When a round of The Program becomes effective, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. Referral agents located in CBAs who prescribe DMEPOS for Medicare beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers. CMS plans to announce the contract suppliers in the spring of 2013.

For purposes of The Program, referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge

planners, social workers, and pharmacists who refer beneficiaries for services in a CBA.

Referral agents play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the program. A beneficiary's *first* contact with the program may be at the point when he or she receives a prescription for a competitively bid item. If the beneficiary resides in a CBA or is visiting a CBA in which he or she needs to obtain a competitively bid item, he or she may need to be directed to a contract supplier.

Email Updates for Referral Agents

In the coming months leading up to the start of The Program, CMS will send out more information that will be helpful for referral agents and guide them through the changes that the new program brings.

In light of the important role that referral agents serve, CMS has adopted the use of a new email update to better communicate the various aspects of The Program and to ensure that official information is released and received by referral agents as quickly as possible. CMS encourages all referral agents to sign up for this new email update to ensure they receive the most accurate and timely information regarding The Program.

To ensure you give Medicare patients correct DMEPOS information, sign up for the [email updates for referral agents](#).

From the MLN: “Medicare Claim Submission Guidelines” Fact Sheet — Revised [\[↑\]](#)

The “[Medicare Claim Submission Guidelines](#)” Fact Sheet (ICN 906764) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on Medicare claim submissions. It includes information about enrolling in the Medicare Program; private contracts with Medicare beneficiaries; filing Medicare claims; deductibles, coinsurance, and copayments; and coordination of benefits.

Medicare Learning Network® Exhibit Schedule [\[↑\]](#)

Just A Reminder. The Medicare Learning Network® will exhibit at the following health care provider conferences in September:

- HealthCare Billing & Management Association
 - September 12 through September 14, 2012
 - Gaylord National Resort & Convention Center on the Potomac
 - National Harbor, Maryland 20745
- American Health Information Management
 - September 29 through October 4, 2012
 - McCormick Place Convention Center
 - Chicago, IL 60616
 - Booth # 646

Mark Your Calendars. The Medicare Learning Network® will be exhibiting at the following health care provider conferences in October:

- American College of Surgeons
 - October 1 through October 3, 2012
 - McCormick Place Convention Center
 - Chicago, IL 60616
 - Booth #1640
- Congress of Neurologic Surgeons
 - October 6 through October 10, 2012
 - McCormick Place Convention Center
 - Chicago, IL 60616
 - Booth # 425
- Advanced Practice In Primary and Acute Care
 - October 4 through October 6, 2012
 - Washington State Convention Center, 8th and Pike
 - Seattle, WA
- Leading Age
 - October 21 through October 23
 - Colorado Convention Center
 - Denver, CO
 - Booth # 2006
- American Academy of Professional Coders
 - October 25 through October 27, 2012
 - Chicago Hyatt Regency
 - Chicago, IL
- American Society for Radiation Oncology
 - October 28 through October 31, 2012
 - Boston Convention and Exhibition Center
 - Boston, MA

Please make a note of these dates and locations and add them to your calendar.

More helpful links...

Check out CMS on:



[#CMSMLN](#)

[The Medicare Learning Network](#)

[Archive of Provider e-News Messages](#)