



# MLN Connects™ Provider eNews

*Part of the Medicare Learning Network®*

Thursday, July 18, 2013

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## MLN Connects™ National Provider Calls

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### Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 — Last Chance to Register

Tuesday, July 23; 1:30-3pm ET

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details: [Eligibility Requirements for Professionals](#).

This call will give eligible professionals an in-depth overview of clinical quality measures (CQMs) included in the final rule for Stage 2 of Meaningful Use for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program. Details on the measures, the recommended core set for reporting purposes, and the 2014 electronic specifications for the Medicare EHR Incentive Program will be provided. Participants will be given an opportunity to engage CMS subject matter experts with questions on CQMs.

*Agenda:*

- Review background information on the EHR Incentive Program: Meaningful Use
- Present Stage 2 requirements, focusing on clinical quality measures
- Explain components of eMeasures in Stage 2
- Provide additional resources for more information
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### Stage 1 and Stage 2 of Meaningful Use for the EHR Incentive Programs — Last Chance to Register

Wednesday, July 24; 1:30-3pm ET

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*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 and Eligibility Requirements for Hospitals](#).

CMS will host an MLN Connects National Provider Call about the Stage 2 Final Rule and how it affects Stage 1 and Stage 2 of meaningful use and other requirements of the EHR Incentive Programs. This call aims to help providers successfully participate in the EHR Incentive Programs and receive an incentive payment.

*Agenda:*

- The extension of Stage 1
  - Changes to Stage 1 meaningful use criteria
  - New and updated Medicaid policies
  - An overview of Stage 2 meaningful use
  - Clinical Quality Measures (CQMs) beginning in 2014
  - Information on Medicare payment adjustments and exceptions
  - A question and answer session to address meaningful use topics

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule — Last Chance to Register**

*Thursday, July 25; 1:30-3pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers.

This MLN Connects Call will provide an overview of the 2014 Physician Fee Schedule (PFS) Proposed Rule. This presentation will cover potential program updates to the Physician Quality Reporting System (PQRS). The topics covered will include changes to reporting mechanisms, individual measures, and measures groups for inclusion in 2014, criteria for satisfactorily reporting for incentive, criteria for avoiding future payment adjustments, requirements for Medicare incentive program alignment and satisfactory participation under the qualified clinical data registry option, which will be established in the PQRS as a result of the American Taxpayer Relief Act of 2012.

The presentation will also provide an overview of the proposals for the value-based payment modifier including how CMS proposes to continue to phase in and expand application of the value-based payment modifier in 2016 based on performance in 2014. The presentation will also describe how the value-based payment modifier is aligned with the reporting requirements under the PQRS.

Lastly, this presentation will provide information on the 2014 PFS Proposed Rule comment period, which allows the public to post comments and suggestions to proposed program requirements.

*Agenda:*

- Introduction
- Review of the proposed PQRS policies under the 2014 PFS Proposed Rule
- Review of the proposed value-based payment modifier policies under the 2014 PFS Proposed Rule
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now**

*Wednesday, July 31; 2:30-3:30pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers.

This MLN Connects Call will walk through the Physician Value (PV) - Physician Quality Reporting System (PQRS) Registration System. The PV-PQRS Registration System is a new application to serve the Physician Value Modifier and PQRS programs. The PV-PQRS Registration system will allow: (1) physician group practices to select their CY 2013 PQRS Group Reporting Mechanism, and if the group has 100 or more eligible professionals, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the CMS-calculated Administrative Claims reporting mechanism for CY 2013 in order to avoid the PQRS negative payment adjustment in CY

2015. A question and answer session will follow the presentation. The PV-PQRS Registration System will be open from July 15, 2013 to October 15, 2013.

Please note that while this call is scheduled for 60 minutes. CMS experts will be available to stay on the line for an additional 30 minutes to take outstanding questions, should they exist, at the end of the scheduled call time. Participants can remain on the line until the conclusion of the call or refer to the call transcript and audio recording (to be posted 7-10 business days after the call) if they are unable to participate beyond the 60 minute scheduled duration.

*Agenda:*

- Introduction/opening remarks
- PV-PQRS registration walkthrough
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

**ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data — Register Now**

*Wednesday, August 7; 3-4pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts.

CMS will host an MLN Connects Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance initiative that ties a facility's quality scores to a payment percentage reduction over the course of a payment year (PY). This call will focus on the steps dialysis facilities need to take to review the data CMS will use to evaluate performance as part of the PY 2014 program.

On July 15, 2013, CMS will make available to each facility a preliminary PY 2014 Performance Score Report (PSR) that "previews" how well it scored on the quality measures CMS will use for determining any payment reductions. CMS encourages every dialysis facility to carefully review its PSR before CMS makes the information available publicly at the end of 2013. Facilities will have from July 15 through August 15, 2013 to complete this important review. Also during this period, facilities will have an opportunity to ask questions about how their scores were calculated, and also have the ability to submit *one* formal inquiry if they find or suspect an error in the score calculations.

*Agenda:*

- How to access and review facility's PSR;
- How CMS calculated a facility's ESRD QIP performance score using quality data;
- What the performance score means to a facility's PY 2014 payment rates;
- When and where to ask questions regarding a PSR, including how to submit *one* formal inquiry;
- Duties and responsibilities to make ESRD QIP performance data transparent to patients;
- Where to access help and get additional information

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

**OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit — Register Now**

*Thursday, August 8; 1:30-3pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Physicians, teaching hospitals, and other interested stakeholders.

OPEN PAYMENTS (Physician Payment Sunshine Act) requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals creating greater transparency around the financial relationships that occur among them. It is important to know that data collection will begin on August 1, 2013. This MLN Connects Call for physicians and teaching hospitals will give an update on program policy, with a focus on third party payments and indirect payments as well as the Physician Resource Toolkit. There will be a question and answer session following the presentation. Don't miss this opportunity to learn from the experts.

*Agenda:*

- Update on program policy, with a focus on Third Party Payments & Indirect Payments
- Physician Resource Toolkit
- Question and answer session

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### **ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 — Registration Now Open**

*Wednesday, August 14; 3-4:30pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts.

CMS will host an MLN Connects Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance quality initiative that ties a facility's performance to a payment reduction over the course of a payment year (PY).

This call will focus on the [proposed rule](#) for operationalizing the ESRD QIP in PY 2016. This proposed rule was published in the Federal Register on July 8. The public will have until August 30, 2013, to submit their comments about the content of the rule. CMS encourages every dialysis facility and ESRD stakeholder to carefully review the proposed rule and participate in the comment period.

After the presentation, participants will have an opportunity to ask questions.

*Agenda:*

- ESRD QIP legislative framework
- Proposed measures, standards, scoring methodology, and payment reduction scale for PY 2016
- Methods for reviewing and commenting on the proposed rule
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program — Registration Opening Soon**

*Thursday, August 15; 1:30-3*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Registration will open soon.

*Target Audience:* [Eligible hospitals](#) and [eligible professionals](#).

Beginning in 2015, Medicare eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that do not successfully demonstrate meaningful use will be subject to a payment adjustment. The payment adjustments for EPs start at 1% and increase each year up to 5% if the provider does not demonstrate meaningful use of Electronic Health Record (EHR) technology. Join the CMS experts on an MLN Connects Call to learn who will be affected, how to apply for an exception if you are eligible, and how the payment adjustment will be applied. *Note: Providers which are not eligible for the Medicare EHR incentive program, or who successfully attest to the Medicaid EHR incentive program, will not be subject to payment adjustments.*

*Agenda:*

- Who is subject to payment adjustments
- Who can request an exception
- Adjustments for professionals
- Adjustments for hospitals and CAHs

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **ICD-10 Basics — Register Now**

*Thursday, August 22; 1:30-3pm ET*

*To Register:* Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

*Target Audience:* Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

Are you ready to transition to ICD-10 on October 1, 2014? Join us for a keynote presentation on ICD-10 basics by Sue Bowman from the American Health Information Management Association (AHIMA), along with an implementation update by CMS. A question and answer session will follow the presentation.

*Agenda:*

- Benefits of ICD-10
- Similarities and differences from ICD-9
- Coding
  - Basics of finding a diagnosis code
  - Placeholder "x"
  - Unspecified codes
  - External cause of injury codes
  - Type of encounter
- Training needs and timelines
- Resources for coding and training
- National implementation issues

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### **Announcements and Reminders**

## How's the Service Provided by Your MAC?

Have you registered to participate in the Medicare Administrative Contractor (MAC) Satisfaction Indicator (MSI) yet? The MSI is a questionnaire that asks about your satisfaction with specific services your MAC provides you, such as claims processing, Medicare enrollment, educational opportunities, and responsiveness to inquiries.

CMS is seeking to collect accurate contact information by having providers complete the [MSI Participant Registration form](#). The form itself is not a survey. It is a method for gathering pertinent contact information such as name, email address, state, etc. It should take less than 1 minute to complete. For each MSI administration, CMS will randomly select its MSI sample from a list of providers who register to become participants.

So, come on. If you are a Medicare Fee-For-Service (FFS) provider, or work on behalf of a Medicare FFS provider (such as a billing agency), and are interested in participating, take a moment to register your contact information by completing the application. Don't miss this opportunity.



## Medicare Provides Coverage for Hepatitis B for Eligible Beneficiaries

*This is Hepatitis. Know it. Confront it.* That's the theme for World Hepatitis Day 2013. This year, on July 28, join the worldwide campaign and urge your patients to get vaccinated. The hepatitis B vaccine provides excellent protection against hepatitis B infection. Additionally, the vaccine is covered at no cost under Medicare Part B for certain eligible individuals at high or intermediate risk.

How common is hepatitis B? There are approximately 43,000 new cases every year in the U.S. and according to the World Hepatitis Alliance the hepatitis virus is going largely ignored around the world. The World Health Alliance is also running a second theme this year, *See No Evil, Speak No Evil, Hear No Evil*, which is encouraging a worldwide conversation to increase awareness about hepatitis.

*For More Information:*

- [MLN Preventive Immunizations Booklet](#)
- [MLN Quick Reference Immunization Billing Chart](#)
- [CMS Immunizations website](#)
- [CMS Prevention General Information website](#)
- [World Hepatitis Alliance – World Hepatitis Day 2013](#)

## Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs

*Model is part of broader HHS efforts to reform the delivery of health care*

On July 16, CMS announced positive and promising results from the first performance year of the Pioneer Accountable Care Organization (ACO) Model, including both higher quality care and lower Medicare expenditures. Made possible by the Affordable Care Act, the Pioneer ACO Model encourages providers and caregivers to deliver more coordinated care for Medicare beneficiaries. This model, launched by the CMS Innovation Center, is part of the Affordable Care Act's efforts to realign payment incentives, promoting high quality, efficient care for Medicare beneficiaries. ACOs, including the Pioneer ACO Model and the Medicare Shared Savings Program, are one way CMS is providing options to providers looking to better coordinate care for patients and use health care dollars more wisely.

### *Pioneer ACO Savings*

Costs for the more than 669,000 beneficiaries aligned to Pioneer ACOs grew by only 0.3 percent in 2012 where as costs for similar beneficiaries grew by 0.8 percent in the same period. 13 out of 32 pioneer ACOs produced shared savings with CMS, generating a gross savings of \$87.6 million in 2012 and saving nearly \$33 million to the Medicare Trust Funds. Pioneer ACOs earned over \$76 million by providing coordinated, quality care. Only 2 Pioneer ACOs had shared losses totaling approximately \$4.0 million. Program savings were driven, in part, by reductions that Pioneer ACOs generated in hospital admissions and readmissions.

### *Pioneer ACO Quality*

All 32 Pioneer ACOs successfully reported quality measures and achieved the maximum reporting rate for the first performance year, with all earning incentive payments for their reporting accomplishments. Overall, Pioneer ACOs performed better than published rates in fee-for-service Medicare for all 15 clinical quality measures for which comparable data are available. (Seven measures had no comparable data in the published literature.) In addition, Pioneer ACOs were rated higher by ACO beneficiaries on all four patient experience measures relative to the 2011 Medicare fee-for-service results.

CMS anticipates having Medicare Shared Savings Program first year results later this year.

For more information:

- [Pioneer ACO Model](#) website
- [Lower Costs, Better Care: Reforming Our Health Care Delivery System](#) Fact Sheet

Full text of this excerpted [CMS press release](#) (issued July 16).

### **Medicare Contracting Reform Website: New Name and URL**

CMS has changed the name of its external internet website for Medicare Administrative Contractors. The new name of the website is "[Medicare Administrative Contractors](#)." New information includes an update on the Vision for the Medicare Fee-for-Service Program and a new page that supports the geographic assignment rule, "Provider Assignments and MACs". Information from the previous Medicare Contracting Reform website is still available and accessible using the new navigation links, including highlights of current awards and protests, status of MAC contracts and fact sheets, as well as maps of all MAC jurisdictions. If you have any questions, please contact: [MAC\\_WebTeam@cms.hhs.gov](mailto:MAC_WebTeam@cms.hhs.gov).

### **PV-PQRS Registration System Opening July 15**

The Physician Value (PV) - Physician Quality Reporting System (PQRS) Registration System is a new application to serve the Physician Value Modifier and PQRS programs. The PV-PQRS Registration System will be open from July 15 to October 15, 2013 and will allow the following:

- Physician group practices to select their CY 2013 PQRS Group Reporting Mechanism, and if applicable, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier
- Individual eligible professionals to select the Administrative Claims reporting mechanism for CY 2013

An Individuals Authorized Access to the CMS Computer Services (IACS) account is required to access the PV-PQRS Registration System. You can now sign up for a new IACS account or modify an existing IACS account on the [CMS Applications Portal](#). *Please note:* IACS has been modified to accept PTANs that are less than 10 characters long. We urge representatives of group practices and EPs to request an IACS account with a PV-PQRS Registration System role or modify an existing account to add a PV-PQRS Registration System role on the [CMS Applications Portal](#) as soon as possible.

*For More Information:*

For additional information about getting an IACS account with a PV-PQRS Registration System role, please visit the

Physician Feedback Program/Value-Based Payment Modifier [Self Nomination/Registration](#) web page. Visit the [Physician Feedback Program](#) website for more information on the Value-based Payment Modifier.

### Data Submission Deadline for the IRF and LTCH Quality Reporting Programs: August 15

The Centers for Disease Control (CDC) has established quarterly data submission deadlines that Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs) must follow for the submission of healthcare acquired infection (HAI) data to the National Healthcare Safety Network (NHSN).

The CDC quarterly data submission periods and deadlines are as follows:

Quarter	Data Submission Dates	Final Date Submission Deadline
Quarter 1	January 1, 2013 – March 31, 2013	August 15, 2013
Quarter 2	April 1, 2013 – June 30, 2013	November 15, 2013
Quarter 3	July 1, 2013 – September 30, 2013	February 15, 2014
Quarter 4	October 1, 2013 – December 31, 2013	May 15, 2014

As noted in the chart above, data from the 1<sup>st</sup> quarter of 2013 (January 1 – March 31, 2013) for the ACA Section 3004 IRF and LTCH quality reporting programs must be entered into NHSN by *no later than August 15, 2013*:

- IRFs must submit the following HAI data to NHSN:
  - All CAUTI data for the period of January 1 to March 31, 2013
- LTCHs must submit the following HAI +data to NHSN:
  - All CAUTI data from the period of January 1 to March 31, 2013
  - All CLABSI data from the period of January 1 to March 31, 2013

#### Helpful Hints:

- Please make sure at least one individual at your facility has an active digital certificate and has been assigned appropriate user rights in NHSN so they may enter and view the facility's data.
- To ensure your data have been correctly entered into NHSN, please make sure to verify that your monthly reporting plans are complete, you've entered appropriate summary and event data, and you've cleared all alerts from your NHSN facility homepage.
- For additional guidance on ensuring your data are accurately sent to CMS for Quality Reporting purposes, please visit the [CDC](#) website and navigate to the appropriate section(s) for your facility type.
- If you have any questions please contact the NHSN Helpdesk: [NHSN@cdc.gov](mailto:NHSN@cdc.gov).

### Review New and Updated FAQs on the EHR Incentive Programs

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS recently posted two new FAQs and an updated FAQ to the [CMS FAQ system](#). We encourage you to stay informed by taking a few minutes to review the new information below.

#### New FAQs:

- When can a hospital use the case number threshold exemption for the clinical quality measure (CQM) requirement of meaningful use? [Read the answer here.](#)
- If a provider who is participating in the EHR Incentive Program either retires or opts out of Medicare or Medicaid, can he/she still receive an incentive payment? [Read the answer here.](#)

*Updated FAQ:*

Can attestation information submitted for the EHR Incentive Programs be updated, changed, cancelled or withdrawn after successful submission in the EHR Registration and Attestation System? [Read the answer here.](#)

*Want more information about the EHR Incentive Programs?*

Make sure to visit the [CMS EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

## **Claims, Pricer, and Code Updates**

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### **Demand Letters to Medicare Providers and Suppliers Associated with an Item or Service Provided to Incarcerated Beneficiaries**

Recently, CMS initiated recoveries from providers and suppliers based on data that indicated that the beneficiary was incarcerated on the date of service (DOS). Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. Medicare has identified previously paid claims that contain DOS that partially or fully overlap a period when the beneficiary was incarcerated based on information from the Social Security Administration (SSA). A large number of overpayments have been identified and demand letters released with appeals instructions. At this time, CMS asks that providers do not file appeal requests. This issue will be resolved more quickly and efficiently if providers follow the instructions below.

There may be instances where providers believe that the beneficiary was not incarcerated when the service was provided. However, a beneficiary may be “incarcerated” even when the individual is not confined within a penal facility. For example, a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation may, nevertheless, be in the custody of authorities under a penal statute. In such cases, Medicare payment may be barred. Providers receiving demand letters for denial of claims because the beneficiary’s SSA record indicates incarceration on the DOS, and who have reason to believe that the beneficiary was not incarcerated on the DOS, may wish to contact the beneficiary to gather as much information as possible.

#### *Information Gathered Indicates SSA Record May Need to be Updated*

If a beneficiary did not inform the SSA of his or her release from custody, this may result in his or her record being incorrect. If a provider believes this is the case, the provider may wish to encourage the beneficiary to contact his or her local SSA office in order to have his or her records updated.

It can take up to one month for the beneficiary’s Medicare eligibility file to be updated with the revised SSA information. If the beneficiary tells the provider that SSA is updating his or her records, we suggest the provider contact the Medicare Administrative Contractor using the contact information on the overpayment demand letter.

#### *Information Gathered Indicates SSA Record is Current*

If the provider believes that the beneficiary was not incarcerated on the DOS in question and the beneficiary advises that SSA’s records are currently accurate, the provider can contact his or her local CMS [Regional Office](#) by fax.

At a minimum, providers should be prepared to submit the following information to the appropriate CMS Regional Office:

- Fax Subject: Incarcerated Beneficiary Claim Issue
- Provider Name and Contact information:
- Beneficiary Name:
- Health Insurance Claim Number:
- Dates of Service:
- Claim Number (ICN/DCN):

- Reason why incarceration information for the DOS is incorrect:

### **Final Update for ICD-9-CM Codes Now Available**

The last official ICD-9-CM code titles (full and abbreviated titles) for October 1, 2013 are now available on the [ICD-9-CM](#) website. ICD-10 will be implemented on October 1, 2014. CMS has been maintaining ICD-9-CM codes since 1979, and this final update is an historic occasion.

### **MLN Education Products Update**

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#### **New MLN Provider Compliance Fast Fact**

A new fast fact is now available on the [MLN Provider Compliance](#) web page. This web page provides the latest [MLN Education Products](#) and [MLN Matters® Articles](#) designed to help Medicare FFS providers understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

#### **“Transitional Care Management Services” Fact Sheet — Released**

The “[Transitional Care Management Services](#)” Fact Sheet (ICN 908682) was released and is now available in downloadable format. This fact sheet is designed to provide education on Transitional Care Management (TCM) services. It includes the requirements for TCM services, health care professionals who may furnish TCM services, TCM services settings, components included in TCM, billing TCM services, and Frequently Asked Questions.

#### **“Medicare Coverage of Imaging Services” Fact Sheet — Revised**

The “[Medicare Coverage of Imaging Services](#)” Fact Sheet (ICN 907164) has been revised and has a brand new title (formerly known as “Medicare Coverage of Radiology and Other Diagnostic Services”). This fact sheet is now also available as an electronic publication (e-pub) and through a QR code. This fact sheet is designed to provide education on Medicare coverage, billing and payment of imaging and image-guided procedures.

The e-pub format is available under the “Related Links” section of the publication’s detail page. The QR code is also located on the detail page. Instructions for downloading the e-publication and how to scan a QR code are available at “[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication.](#)”

#### **“ICD-10-CM/PCS Myths and Facts — Revised**

The “[ICD-10-CM/PCS Myths and Facts](#)” Fact Sheet (ICN 902143) was revised and is now available in hard copy format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes responses to myths about ICD-10-CM/PCS and resource information. 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.

#### **“ICD-10-CM/PCS The Next Generation of Coding — Revised**

The “[ICD-10-CM/PCS The Next Generation of Coding](#)” Fact Sheet (ICN 901044) was revised and is now available in hard copy format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th

Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date; ICD-10-CM/PCS – an improved classification system; ICD-10-CM/PCS examples; structural differences between International Classification of Diseases, 9th Edition, Clinical Modification and ICD-10-CM/PCS; continued use of Current Procedural Terminology codes; and use of external cause and unspecified codes in ICD-10-CM. 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.

#### “Remittance Advice Resources” Fact Sheet—Reminder

The “[Remittance Advice Resources](#)” Fact Sheet (ICN 908329) was released and is now available in downloadable format. This fact sheet is designed to provide education on electronic remittance advice (ERA) software. It includes information on commercial and free software options.

#### “Remittance Advice Information: An Overview” Fact Sheet — Reminder

The “[Remittance Advice Information: An Overview](#)” Fact Sheet (ICN 908325) was released and is now available in downloadable format. This fact sheet is designed to provide education on the Remittance Advice (RA). It includes general information about the RA, the benefits of using the electronic RA, what kind of information is in an RA, and what to do once you get one.

[Register](#) for an opportunity to rate your Medicare Administrative contractor. [Learn more](#)



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