



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

Thursday, November 14, 2013

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MLN Connects™ National Provider Calls

Streamlined Access to PECOS, EHR, and NPPES — Last Chance to Register

Friday, November 15; 2-3:30 ET

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

Target Audience: All Medicare Fee-For-Service providers, as well as [Professionals](#) and [Hospitals](#) eligible for the Medicaid Electronic Health Record (EHR) Incentive Program.

Changes have been made to simplify the way providers and suppliers access the Provider Enrollment Chain and Ownership System (PECOS), the Electronic Health Records (EHR) Incentive Program, and the National Plan and Provider Enumeration System (NPPES). These updates, available since October 7, improve the user experience when registering as an individual practitioner, authorized or delegated official of an organization, or someone working within PECOS on behalf of a provider or supplier (also known as a surrogate). This MLN Connects Call will provide detailed instructions on these changes.

The new process will:

- Allow registered users to manage and reset their user ID and password online without calling a CMS Help Desk.
- Provide a simple and secure way for providers and suppliers to authorize individuals or groups of individuals to act on their behalf in PECOS and EHR.
- Allow designated authorized officials already on file with Medicare to be quickly approved to access PECOS without the need to submit documentation to CMS for verification prior to submitting the application.
- Allow organizations with potentially large numbers of credentialing or support staff to manage staff access to the various functions.
- Increase security to reduce the risk of provider identity theft and unauthorized access to systems.

Important Note: If you already have a user ID and password from NPPES, or currently access PECOS, NPPES, and/or EHR, your accounts will not be affected by this change. You can continue to use your established user ID and password to access the systems.

Agenda:

- Opening remarks
- Access Changes for PECOS, EHR, NPPES
- 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.

National Partnership to Improve Dementia Care in Nursing Homes — Register Now

Monday, November 25; 2-3:30pm ET

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

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

CMS has developed a national partnership to improve the quality of care provided to individuals with dementia living in nursing homes. This partnership is focused on delivering health care that is person-centered, comprehensive, and interdisciplinary. By improving dementia care through the use of individualized, person-centered care approaches, CMS

hopes to continue to reduce the use of unnecessary antipsychotic medications in nursing homes and eventually other care settings as well. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

During this MLN Connects Call, CMS subject matter experts will provide a brief overview of the progress that has been made so far during the implementation of this national partnership. Additional speakers will be presenting on the CMS Hand in Hand training series. A question and answer session will follow the presentation.

Agenda:

- National partnership overview
- Using Hand in Hand to improve dementia care
- Closing and next steps
- 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.

2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 — Registration Now Open

Tuesday, December 17; 1:30-3pm

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, and other healthcare professionals.

The December 17 MLN Connects National Provider Call provides an overview of the 2014 Physician Fee Schedule (PFS) Final Rule. This presentation covers program updates to the Physician Quality Reporting System (PQRS). In particular, this call includes details on how an eligible professional (EP) or group practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment. In lieu of satisfactory reporting, the call also covers how to meet the criteria for satisfactory participation under the new qualified clinical data registry option, which will be implemented in 2014 as a result of the American Taxpayer Relief Act of 2012. In addition to the PQRS, this presentation contains additional program updates to the Electronic Health Record (EHR) Incentive Program and Physician Compare. A question and answer session follows the presentation.

Agenda:

- Program updates for PQRS
- How an EP or Group Practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment
- Criteria for satisfactory participation under the new qualified clinical data registry option
- Program updates for EHR Incentive Program and Physician Compare
- 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.

MLN Connects™ Videos

MLN Connects™ Videos on ICD-10

Are you ready to transition to ICD-10 on October 1, 2014? MLN Connects™ videos on the CMS YouTube Channel can help you prepare.

- In the “[ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project](#)” video, Pat Brooks and Dr. Daniel Duvall from the Center for Medicare, Hospital and Ambulatory Policy Group discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding.
- Video slideshow presentations from MLN Connects National Provider Calls:
 - August 22, 2013 – [ICD-10 Basics](#): Keynote presentation by Sue Bowman from the American Health Information Management Association (AHIMA).
 - April 18, 2013 – [Begin Transitioning to ICD-10 in 2013](#): CMS Subject matter experts review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies.

CMS Events

Learn More About Open Payments Registration and Data Submission in Upcoming Webinar

Tuesday, November 19; 1-3pm ET

CMS will present the first two sessions in a series of technology-focused webinars designed to introduce features of the Open Payments system currently in development.

- Webinar 1 (1-2pm): Open Payments Registration — This first hour is targeted to individuals who represent manufacturers of drugs, devices, biologicals, or medical supplies, plus distributors, group purchasing organizations (GPOs), or other entities required to submit data under Open Payments. Other interested participants are welcome to attend.
- Webinar 2 (2-3pm): Data Submission — This second hour is targeted to individuals *responsible for creating data submission files* for manufacturers of drugs, devices, biologicals, or medical supplies, plus distributors, GPOs, or other entities submitting data under Open Payments. Other interested participants are welcome to attend.

To [register](#): enter your name and email address into the box titled “Complete this form to enter the webinar.” Once you’ve submitted the required registration information, you’ll receive an automatic confirmation email.

On December 3, 2013, CMS will host a follow-up Q&A session after participants have had the opportunity to fully review the data submission resources. More information on that webinar will be available following the November 19 webinars.

Details on the other upcoming sessions in the technology webinar series, as well as links to recordings of these sessions, will be available soon on the [Open Payments Events](#) web page. Please submit any program inquiries to OpenPayments@cms.hhs.gov.

Announcements

Grandfathering Notices for DMEPOS Competitive Bidding Round 1 Recompete Due November 18

CMS is required by law to recompetete contracts under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (the Program) at least once every three years. The Round 1 Rebid contracts will expire on December 31, 2013, and the Round 1 Recompetete contracts and prices are scheduled to go into effect on January 1, 2014.

When a round of the Program becomes effective in a competitive bidding area (CBA), beneficiaries with Original Medicare who obtain competitively bid items in that CBA must obtain these items from a contract supplier for that round for Medicare to pay, unless an exception, such as the grandfathering exception, applies. All suppliers that do not have a Round 1 Recompetete contract and furnish competitively bid rented durable medical equipment (DME) or oxygen

and oxygen equipment to beneficiaries in Round 1 CBAs must decide if they will elect to become grandfathered suppliers and notify beneficiaries of their grandfathering decisions.

CMS would like to remind all non-contract suppliers that furnish competitively bid rented DME or oxygen and oxygen equipment to beneficiaries in Round 1 CBAs of the following upcoming deadlines:

1. A non-contract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary who resides in a Round 1 CBA and is currently renting competitively bid oxygen and oxygen equipment or DME from that supplier. These notifications must be sent by November 18, 2013.
2. A non-contract supplier that elects not to become a grandfathered supplier is required to pick-up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting competitively bid DME or oxygen and oxygen equipment and who reside in a Round 1 CBA. The 30-day notification to the beneficiary must be sent by November 18, 2013, and must be in writing.

For detailed information about grandfathering, including the items that are eligible to be grandfathered, notification requirements, and sample notification letters, please go to the Competitive Bidding Implementation Contractor (CBIC) website at www.dmecompetitivebid.com, select "Round 1 Recompete," and then "Grandfathering Information."

Reassigning Benefits Using the Internet-based PECOS System

Over the last year, CMS has listened to your feedback about Internet-based [PECOS](#) and made improvements to increase access to more information. PECOS is easier to use than ever with the following reassignment upgrades that are now available:

Physicians and non-physician practitioners can now reassign their benefits to a Medicare enrolled Critical Access Hospital billing under Method II (CAH II), which allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs) if they are not eligible to participate under any other services or enrollment. *Note:* CAH II are the *only* entities eligible to accept reassignments on the part A side, it does not apply to any other part A entity. If the entity receiving the reassigned benefits is *not* a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

- For more information on Part A reassignments to CAH II's please refer to [MLN Matters® Article #MM8387](#), "Reassignment to Part A Critical Access Hospitals billing under Method II (CAH II)"
- In addition, Part B Organizational Providers/Suppliers (including Ambulatory Surgical Centers (ASCs)) and CAH II providers can initiate a reassignment of benefits with another Medicare enrolled physician or non-physician practitioner as part of their enrollment transaction (i.e., new enrollment or change of information application).
- In the Reassignment topic, the practitioner, CAH II provider or part B Organizational provider/supplier can identify the individual or organization with whom they wish to establish a reassignment of benefits. Also from this section is the ability to designate a primary and/or secondary practice location where the practitioner renders services from a drop down box identifying all the organization's finalized locations. Practice location changes submitted by the organization but not yet finalized by the MAC will not appear in the dropdown box until the MAC has completed processing the change.
- Each reassignment update will receive its own tracking ID and can be tracked separately from other enrollment transactions. All reassignment updates will be routed to the Part B Medicare Administrative Contractor (MAC) for processing regardless of who submitted the change (i.e., practitioner or organizational provider/supplier).
- Required and Supporting Documentation from the Submission Page that are not applicable to the Reassignment scenarios have been removed.

The My Enrollments page will display a count of active reassignments and pending reassignment applications for the provider/supplier as well as a new section to View/Manage Reassignments. The new section list will provide details on all current reassignments and applications that are pending.

- The *Pending Reassignments Applications* section will display the following information:
 - Name/Legal Business Name (LBN)
 - Status
 - Tracking Id
 - Action
- The *Active Reassignment Report* will display the following information:
 - Relationship
 - Provider Name/LBN
 - National Provider Identifier (NPI)
 - Current Enrollment Status,
 - Enrollment State,
 - Revalidation Notice Sent Date, and
 - Revalidation Status
- By clicking the “Download Report” button the user is able to download the full report in an excel format.
- A “Manage Reassignments” feature is also available from this page and will allow the provider/supplier to add a new reassignment or remove an existing reassignment without navigating back to the My Enrollments page.

To access internet-based PECOS, go to the [PECOS](#) website.

Learn When EHR Payment Adjustment for Medicare Eligible Hospitals Begin

Subsection (d) hospitals that are eligible to participate in the Medicare EHR Incentive Program must meet meaningful use requirements to avoid the federally-mandated payment adjustments that begin in FY 2015. The adjustment is determined by the hospital’s reporting period in a prior year. Find out how your hospital’s participation start year will affect its 2015 payment adjustments:

For Hospitals that Began Participation in 2011 or 2012:

Eligible hospitals that first demonstrated meaningful use in FY 2011 or 2012 must demonstrate meaningful use for a full year in FY 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by *November 30, 2013*.

For Hospitals that Begin Participation in 2013:

Eligible hospitals that first demonstrate meaningful use in FY 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by *November 30, 2013*.

For Hospitals that will Begin Participation in 2014:

Eligible hospitals that first demonstrate meaningful use in fiscal year 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first nine months of fiscal year 2014 (i.e. they must begin the 90-day reporting period by April 1), and hospitals must attest to meaningful use no later than July 1, 2014, in order to avoid the payment adjustments.

Avoiding Payment Adjustments in the Future

Once hospitals begin participation in the Medicare EHR Incentive Program, they must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. For more information on timing and how to avoid payment adjustments, view the [Payment Adjustment and Hardship Exemptions Tipsheet for Eligible Hospitals and Critical Access Hospitals](#).

Want more information about the EHR Incentive Programs?

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

Review Important Payment Adjustment Information for Medicare EPs

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on *January 1, 2015*. CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments. Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

If you began in 2011 or 2012

If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

If you began in 2013

If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.

If you plan to begin in 2014

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

Avoiding Payment Adjustments in the Future

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.

Helpful Resources

For more information on EP payment adjustments, view the [Payment Adjustments and Hardship Exceptions Tipsheet](#) for EPs.

Want more information about the EHR Incentive Programs?

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

Request a Review of 2012 PQRS Participation Results

Eligible professionals (EPs), designated support staff/vendors, and group practices who submitted data for the 2012 Physician Quality Reporting System (PQRS) program can now request to have an informal review of their 2012 PQRS reporting performance. An informal review may be requested if the [feedback report](#) reveals that the EP or group practice did not earn the 2012 PQRS incentive payment when they believe they should have, or when they believe the payment amount was incorrect. Informal review requests will be accepted from *November 1, 2013 through February 28, 2014*.

The informal review will be for all 2012 reporting methods, including:

- Claims
- Qualified registry

- Qualified EHR
- Group Practice Reporting Option (GPRO) Web Interface (for groups of 100 or more EPs)

Steps to Request an Informal Review

In order to request an informal review of 2012 PQRS performance, CMS must receive a valid informal review request via the web-based tool, Quality Reporting [Communication Support Page](#), during the informal review period. Please follow the steps below to submit a valid request:

- Individual EPs or designated support staff will need to submit a request for an informal review for each individual rendering National Provider Identifier (NPI) for each Tax Identification Number (TIN) under which the requestor submitted 2012 PQRS QDCs or data.
Groups that participated in the GPRO will need to have their main point of contact request an informal review for the TIN under which the GPRO submitted 2012 PQRS Quality-Data Codes (QDCs) or data.
- To submit the request, go to the [Communication Support Page](#) between November 1, 2013 and February 28, 2014.
- Complete the mandatory fields in the online form, including the appropriate justification, for the request to be deemed valid. Failure to complete the form in full will result in the inability to process the request. CMS or the QualityNet Help Desk may contact the requestor for additional information if necessary.

PQRS Resources

For more information about the informal review, see the [2012 PQRS Informal Review Made Simple](#) fact sheet or visit the [PQRS](#) website. You can also learn about other eHealth initiatives at CMS by visiting the [CMS eHealth](#) website.

Identify How ICD-10 Will Affect Your Practice

In order to be fully prepared for the October 1, 2014, ICD-10 transition, you need to know exactly how ICD-10 will affect your practice. Although many people associate coding with submitting claims, in reality, ICD codes are used in a variety of processes within clinical practices, from registration and referrals to billing and payment. The following is a list of important questions to help you think through where you use ICD codes and how ICD-10 will affect your practice. By making a plan to address these areas now, you can make sure your practice is ready for the ICD-10 transition.

- Where do you use ICD-9 codes? Keep a log of everywhere you see and use an ICD-9 code. If the code is on paper, you will need new forms (e.g., patient encounter form, superbill). If the code is entered or displayed in your computer, check with your Electronic Health Record (EHR) and/or practice management system vendor to see when your system will be ready for ICD-10 codes.
- Will you be able to submit claims? If you use an electronic system for any or all payers, you need to know if it will be able to accommodate the ICD-10 version of diagnoses and hospital inpatient procedures codes. If your billing system has not been upgraded for the current version of HIPAA claims standards—Version 5010—you will not be able to submit claims. Check with your practice management system or software vendor to make sure your claims are in the HIPAA Version 5010 format and that your system or software can include the ICD-10 version of diagnoses and hospital inpatient procedures codes.
- Will you be able to complete medical records? If you use any type of EHR system in your office, you need to know if it will capture ICD-10 codes. Look at how you enter ICD-9 codes (e.g., do you type them in or select from a drop down menu) and talk to your EHR vendor about your system's capabilities for ICD-10. If your EHR system does not capture ICD-10 codes and you use another terminology (SNOMED), you will still need ICD-10 codes to submit claims.
- How will you code your claims under ICD-10? If you currently code by look up in ICD-9 books, purchase the ICD-10 code books in early 2014. Take a look at the codes most commonly used in your office and begin developing a list of comparable ICD-10 codes. Alternatively, check your software for an ICD-10 look up functionality.
- Are there ways to make coding more efficient? For example, develop a list of your most commonly used ICD-9 codes and become familiar with the ICD-10 codes you will use in the future; and invest in a software program that helps small practices with coding.

Want more information about ICD-10?

Visit the CMS [ICD-10](#) website for the latest news and resources to help you prepare for the *October 1, 2014*, deadline. Sign up for [CMS ICD-10 Industry Email Updates](#) and [follow us](#) on Twitter.

Claims, Pricers, and Codes

Pilot ICD-10 IOCE Code Lists Now Available for Public Comment

The ICD-10 (Integrated Outpatient Code Editor) [IOCE Pilot v14.3 code lists](#) are now available for public comment on the [Pilot I-10 IOCE User Manual](#) web page. This is a pilot version for testing only. The official ICD-10 version will not be released until the official code set is developed for October 1, 2014 implementation. PC and mainframe versions will be available soon from the [National Technical Information Service](#) (NTIS).

ICD-10 MS-DRG Software and Reimbursement Mappings Now Available

The Reimbursement Mappings and ICD-10 Medicare Severity Diagnosis Related Grouper (MS-DRG) software will allow the public to continue to evaluate the conversion of the MS-DRGs from ICD-9-CM codes to ICD-10 codes. ICD-10 will be implemented on October 1, 2014. The final ICD-10 version of the MS-DRGs, version 32.0 (FY 2015) will be subject to formal rulemaking.

- 2014 Reimbursement Mappings – [Diagnosis Codes and Guides](#)
- 2014 Reimbursement Mappings – [Procedure Codes and Guides](#)
- The ICD-10 Pilot Version 31.0 Mainframe and PC version of the ICD-10 MS-DRGs and Medicare Code Editor (FY 2014 version) are now available from the [National Technical Information Service](#) (NTIS) or through the link on the [ICD-10 MS-DRG Conversion Project](#) web page

FY 2014 Inpatient Prospective Payment System Pricer File Update 3 — Revised

The Inpatient FY 2014.3 Pricer software with revised provider and core-based statistical area (CBSA) data has been posted to the [Acute Inpatient PPS](#) website.

MLN Educational Products

“Skilled Nursing Facility Prospective Payment System” Fact Sheet — Revised

The “[Skilled Nursing Facility Prospective Payment System](#)” Fact Sheet (ICN 006821) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Skilled Nursing Facility Prospective Payment System (SNF PPS). It includes the following information: background and elements of the SNF PPS.

“The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation” Fact Sheet — Reminder

“[The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Accreditation](#)” Fact Sheet, (ICN 905710) is available in a downloadable format. This fact sheet is designed to provide education on DMEPOS. It includes information so suppliers can meet DMEPOS Quality Standards established by CMS and become accredited by a CMS-approved independent national Accreditation Organization (AO). There is also information on the types of providers who are exempt.

MLN Products Available In Electronic Publication Format

The following fact sheets are now available as electronic publications (EPUBs) and through QR codes. Instructions for downloading EPUBs and how to scan a QR code are available at "[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication](#)" on the CMS website.

- The "[Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority](#)" Fact Sheet (ICD 908084) is designed to provide education on Medicare's policy to generally not pay for medical items and services furnished to beneficiaries who are incarcerated or in custody at the time the items and services are furnished. It includes the following information: policy background, including the definition of individuals who are in custody (or incarcerated) under a penal statute or rule; determining whether a beneficiary is in custody under a penal statute or rule; Medicare claims processing for items and services for incarcerated beneficiaries; exception to Medicare policy; and Informational Unsolicited Response.
- The "[September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions](#)" Fact Sheet (ICN 908974) 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 and billing and payment Frequently Asked Questions.



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