



## CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

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

Robin Fritter, Director  
Division of Provider  
Relations & Outreach  
Provider Communications  
Group  
Center for Medicare  
Centers for Medicare &  
Medicaid Services

[robin.fritter@cms.hhs.gov](mailto:robin.fritter@cms.hhs.gov)  
410-786-7485

### The e-News for Tue Feb 14 includes...

#### NATIONAL PROVIDER CALLS

- Thu Feb 16 – [Medicare FFS Implementation of HIPAA Version 5010 and D.O Transaction Standards – Clearinghouses and Vendors – Last Chance to Register](#)
- Tue Feb 21 – [Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now](#)
- Tue Feb 28 – [Hospital Value-Based Purchasing Program – Registration Now Open](#)

#### OTHER CALLS, MEETINGS, AND EVENTS

- Thu Feb 23 – [Upcoming Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument](#)

#### ANNOUNCEMENTS AND REMINDERS

- [Medicare Proposes New Steps to Protect Taxpayer Dollars – Affordable Care Act Gives New Authority To Recover Overpayments More Quickly](#)
- [Submit Notice of Intent to Apply for Sun July 1 Start Date for Medicare Shared Savings Program – DUE BY FRI FEB 17](#)
- [CMS Seeks Public Comment on Work of ESRD Network Organizations – due Fri Feb 17](#)
- [ASC X12 Decides Against Proposing Version 6020 for Consideration as Next Version of Standard Under HIPAA](#)
- [New Educational Resources for the Electronic Prescribing Incentive Program](#)
- [New Educational Resources for the Physician Quality Reporting System](#)
- [New Webpage on CQMs Added to the EHR Website](#)
- [It's Not Too Late to Give and Get the Flu Vaccine](#)

#### CLAIMS, PRICER, AND CODE UPDATES

- [CMS Furnishes List of Off-The-Shelf Orthotic Healthcare Common Procedures Coding System Codes](#)
- [Inpatient Psychiatric Facility Prospective Payment System FY2012 Pricer File Update](#)
- [Inpatient Rehabilitation Facility Prospective Payment System FY2012 Pricer File Update](#)
- [Skilled Nursing Facility Prospective Payment System FY2012 PC Pricer Update](#)

#### UPDATES FROM THE MEDICARE LEARNING NETWORK®

- [New Fast Fact on MLN Provider Compliance Webpage](#)

- [“Updating Beneficiary Information with Coordination of Benefits Contractor” MLN Matters Article Released](#)
- [“Clinical Laboratory Fee Schedule” Fact Sheet Revised](#)
- [MLN Provider Exhibit Program Schedule](#)

**National Provider Call: Medicare FFS Implementation of HIPAA Version 5010 and D.0 Transaction Standards – Clearinghouses and Vendors – Last Chance to Register** [↑]

*Thu Feb 16; 1:30-3pm ET*

CMS will host a National Provider Call regarding Medicare FFS implementation of HIPAA Version 5010 and D.0 transaction standards, focusing on addressing recommendations made by the industry as well as outstanding fixes impacting the Part A and Part B Version 5010 transition.

*Target Audience:* This call will focus on Vendors and Clearinghouses that may be experiencing difficulties with the Version 5010 transition

*Agenda (there will be no slide presentation for this call):*

- General Version 5010 Update: Where are we currently?
- General Industry Feedback
- Outstanding Common Edits and Enhancement Module (CEM) Fixes
- Open Discussion

*Registration Information:* In order to receive the call-in information, you must register for the call. *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.* For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

If you would like to submit a question related to this topic in advance of, during, or following the call, please email your inquiry to the 5010 FFS Information resource mailbox at [5010FFSinfo@CMS.hhs.gov](mailto:5010FFSinfo@CMS.hhs.gov). Note that this resource box will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during the call.

- Additional material related to HIPAA transaction standards in today’s e-News... [\[next\]](#)

**National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now** [↑]

*Tue Feb 21; 1:30-3pm ET*

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing (eRx) Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

*Target Audience:* All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

*Agenda:*

- Opening Remarks
- Program Announcements
- Overview of claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive Program
- Question & Answer Session

*Registration Information:* In order to receive the call-in information, you must register for the call. *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.* For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

*Presentation:* The presentation for this call will be posted at least one day in advance at [http://www.CMS.gov/PQRS/04\\_CMSSponsoredCalls.asp](http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp), in the “Downloads” section of the page.

- Additional material related to the Physician Quality Reporting System and eRx in today’s e-News... [\[next\]](#)

### **National Provider Call: Hospital Value-Based Purchasing Program – Registration Now Open [\[↑\]](#)**

*Tue Feb 28; 1:30-3pm ET*

CMS will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital’s baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

*Target Audience:* Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers

#### *Agenda:*

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

*Registration Information:* In order to receive the call-in information, you must register for the call. *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.* For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

*Presentation:* The presentation for this call will be posted at least one day in advance at <http://www.CMS.gov/Hospital-Value-Based-Purchasing>, in the “Downloads” section of the page.

### **Upcoming Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument [\[↑\]](#)**

*Thu Feb 23, 2012; 1-2pm ET*

An informational Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) to cover topics such as the data specification updates for the Mon Oct 1, 2012, release and the new process to submit IRF-PAI records to the Assessment Submission and Processing (ASAP) System is scheduled for Thu Feb 23, 1-2pm.

To facilitate this call, we are requesting that vendors review the draft technical specifications prior to this call and submit any comments or questions related to the technical aspects of the IRF-PAI to [IRFTechIssues@cms.hhs.gov](mailto:IRFTechIssues@cms.hhs.gov) by 6pm on Thu Feb 16.

Technical specifications can be found in the “Downloads” section of the webpage at [http://www.CMS.gov/InpatientRehabFacPPS/06\\_Software.asp](http://www.CMS.gov/InpatientRehabFacPPS/06_Software.asp). Additional information about the Thu Feb 23 Vendor Call, specifically, can be found in the February Vendor Call Memo document found in the “Downloads” section of the page at [http://www.CMS.gov/InpatientRehabFacPPS/11\\_TechInfo.asp](http://www.CMS.gov/InpatientRehabFacPPS/11_TechInfo.asp).

➤ Additional material related to Inpatient Rehabilitation Facilities in today’s e-News... [\[next\]](#)

### **Medicare Proposes New Steps to Protect Taxpayer Dollars – *Affordable Care Act* Gives New Authority To Recover Overpayments More Quickly [\[↑\]](#)**

On Tue Feb 14, CMS proposed that providers and suppliers must report and return self-identified overpayments either within 60 days of the incorrect payment being identified or on the date when a corresponding cost report is due, whichever is later.

The new announcement is one in a series of steps Medicare is taking to protect taxpayer dollars, including efforts to prevent overpayments from occurring. These efforts include letting private auditors working on behalf of Medicare catch wasteful spending before it happens, by expanding the use of Recovery Audit Contractors; testing changes to outdated hospital billing systems to help prevent over-billing; and changing processes for approving payments for medical equipment with high error rates.

A Medicare overpayment means any funds that a person receives or retains under Medicare to which the person is not entitled. Examples of overpayments in Medicare include:

- Duplicate submission of the same service or claim
- Payment to the incorrect payee
- Payment for excluded or medically-unnecessary services
- Payment for non-covered services

Before the *Affordable Care Act*, providers did not face an explicit deadline for returning taxpayers’ money. Thanks to the *Affordable Care Act*, there will be a specific timeframe by which overpayments must be reported returned. Any failure to report and return the overpayment within the applicable time frame could be a violation of the *False Claims Act*. Providers also could be subject to civil monetary penalties or excluded from participating in federal healthcare programs for failure to report and return an overpayment.

To read the proposed rule that would require providers and suppliers receiving funds under the Medicare program to report and return overpayments within specific timeframes, visit the *Federal Register* at <http://s3.amazonaws.com/public-inspection.federalregister.gov/2012-03642.pdf> (or, after Thu Feb 16, visit <http://www.FederalRegister.gov/a/2012-03642>).

*The full text of this excerpted CMS press release (issued Tue Feb 14) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4266>.*

### **Submit Notice of Intent to Apply for Sun July 1 Start Date for Medicare Shared Savings Program – DUE BY FRI FEB 17 [\[↑\]](#)**

If you are interested in applying for participation for the Sun July 1, 2012, start date for the Medicare Shared Savings Program, please submit a Notice of Intent to Apply by *FRI FEB 17, 2012*. For more information, visit [http://www.CMS.gov/SharedSavingsProgram/37\\_Application.asp](http://www.CMS.gov/SharedSavingsProgram/37_Application.asp).

## **CMS Seeks Public Comment on Work of ESRD Network Organizations – due Fri Feb 17** [\[↑\]](#)

CMS is soliciting comments about its recently-released draft Statement of Work (SOW) for its End Stage Renal Disease (ESRD) Network Organization Program contractors.

The draft SOW delineates activities and tasks each of the ESRD Network Organization contractors will perform in support of the CMS ESRD Quality Improvement Program; the draft SOW outlines the objectives, priorities, strategies, and roles the Networks would play in implementing the CMS ESRD Quality Improvement Program in the coming years.

The program consists of a network of 18 organizations across the country, which serve geographic areas based on the number and concentration of beneficiaries with ESRD. These organizations work with consumers and providers of ESRD services to assure that patients receive the best care for individuals with renal failure. More background about the ESRD Network Organization Program can be found is on the CMS website at <http://www.CMS.gov/ESRDNetworkOrganizations>.

Please note that while CMS is interested in comments about the content of the draft SOW, the Agency is still in the process of developing the acquisition strategy in support of this SOW. To review the draft SOW, please visit the Federal Business Opportunities website at [www.FBO.gov](http://www.FBO.gov) and search for solicitation "[CMS2012ESRDSOW](#)."

Please submit your comments on the SOW to [Renee.Dupee@cms.hhs.gov](mailto:Renee.Dupee@cms.hhs.gov) no later than 2pm ET, Fri Feb 17, making sure to include "ESRD SOW Comments" in the subject line. CMS will not address individual questions to the draft SOW; however, CMS will consider industry comments as we finalize the draft SOW in the coming months.

Thank you for your support in improving healthcare quality for Medicare beneficiaries and all Americans.

## **ASC X12 Decides Against Proposing Version 6020 for Consideration as Next Version of Standard Under HIPAA** [\[↑\]](#)

The Accredited Standards Committee X12 (ASC X12) recently announced that it will not propose Version 6020 for consideration as the next version of the standard under the *Health Insurance Portability and Accountability Act (HIPAA)*. In its press release, ASC X12 stated that after listening to and reviewing testimony to the National Committee on Vital Health Statistics (NCVHS), holding discussions with healthcare industry stakeholders and CMS representatives, and acknowledging the many health IT initiatives underway, it decided not to recommend its Version 6020 TR3s to the Designated Standards Maintenance Organizations (DSMO). ASC X12's decision removes the option that this version would be considered for adoption under *HIPAA*.

In announcing its decision, ASC X12 noted that the healthcare industry is better served by focusing on upgrading to Version 5010 standards this year. Lessons learned from this implementation will generate better information that can be applied to changes to the next version of the standard. Furthermore, industry participation in that process will be more robust. CMS supports ASC X12's caution that even though the 6020 version will not be recommended for adoption, stakeholder input is still imperative. The 6020 version will still serve as the basis for the next version, but industry will have much-needed time to determine changes that are needed.

CMS will continue to support the work of ASC X12, the DSMO, other standards development organizations, operating rule entities, and industry stakeholders to improve the process for developing, adopting and maintaining standards and implementation specifications. Please visit the [ASC X12 website](#) for more information on this decision.

*Keep Up to Date on Version 5010 and ICD-10.* Visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the

implementation [widget](#) today!

- Additional material related to HIPAA transaction standards in today's e-News... [\[previous\]](#)

## New Educational Resources for the Electronic Prescribing Incentive Program [\[↑\]](#)

CMS has created a number of useful resources for eligible professionals participating in the Medicare Electronic Prescribing (eRx) Incentive Program, including:

- [2012 eRx Incentive Program: Future Payment Adjustments](#) – This article provides guidance on avoiding future eRx Incentive Program payment adjustments for individual eligible professionals and selected group practices participating in the 2012 eRx Group Practice Reporting Option (GPRO).
- [2012 Physician Quality Reporting System and eRx Incentive Program Group Practice Reporting Option: Participation for the Incentive Payment Made Simple](#) – This factsheet provides guidance for group practices wishing to participate in the 2012 Physician Quality Reporting System and the 2012 eRx Incentive program as a CMS selected group practice.
- [2012 eRx Incentive Program: Participation for the Incentive Payment Made Simple](#) – This factsheet provides step-by-step advice for participating in the 2012 eRx Incentive Program.
- [2012 eRx Incentive Program Updates for 2012](#) – This factsheet contains information about changes to the eRx Incentive Program for 2012 and future payment adjustments as authorized by MIPPA.

To access these and other educational products on the Medicare eRx Incentive Program, visit the “[Educational Resources](#)” section of the [Electronic Prescribing Incentive Program](#) webpage.

- Additional material related to the Physician Quality Reporting System and eRx in today's e-News... [\[next / previous\]](#)

## New Educational Resources for the Physician Quality Reporting System [\[↑\]](#)

CMS has created a number of useful resources for eligible professionals participating in the Physician Quality Reporting System, including:

- [2012 Physician Quality Reporting System: Registry Reporting Made Simple](#) – This document describes registry-based reporting and outlines steps that eligible professionals or practices should take in selecting a registry to work with for the 2012 program year.
- [2012 Physician Quality Reporting System: Electronic Health Record \(EHR\) Reporting Made Simple](#) – This document describes EHR-based reporting and outlines steps that eligible professionals should take in selecting an EHR to work with for the 2012 program year.
- [2012 Physician Quality Reporting System: Maintenance of Certification Program Incentive Made Simple](#) – This factsheet provides steps for successful participation in the Maintenance of Certification Program Incentive. It also explains the role of the qualified Maintenance of Certification Program Incentive entity.
- [2012 Physician Quality Reporting System: Claims-Based Coding and Reporting Principles](#) – This document describes claims-based coding and reporting and outlines steps that eligible professionals or practices should take prior to participating in 2012 Physician Quality Reporting.
- [2012 Physician Quality Reporting System: Made Simple for Reporting the Preventive Care Measures Group via Claims](#) – This factsheet provides guidance on satisfactorily reporting the Preventive Care Measures Group via claims for 2012 Physician Quality Reporting.
- [Physician Quality Reporting System: Updates for 2012](#) – This factsheet includes important information about changes to the Physician Quality Reporting System for 2012, as authorized by MIPPA.
- [2012 Physician Quality Reporting System and Electronic Prescribing \(eRx\) Incentive Program Group Practice Reporting Option \(GPRO\): Participation for the Incentive Payment Made Simple](#) – This factsheet provides guidance for group practices wishing to participate in the 2012 Physician Quality Reporting System and the 2012 eRx Incentive program as a CMS selected group practice.
- [2012 Physician Quality Reporting System Medicare EHR Incentive Pilot: Quick Reference Guide](#) – This Quick-Reference Guide provides direction to eligible

professionals participating in the Medicare EHR Incentive Program on reporting and satisfying the CQM requirements through participation in the Physician Quality Reporting System-Medicare EHR Incentive Pilot.

- [2012 Physician Quality Reporting System: Claims Reporting Made Simple](#) – This document describes claims-based reporting and outlines steps that eligible professionals or practices should take prior to participating. It also provides helpful reporting tips for eligible professionals and their billing staff.

To access these and other educational products on the Physician Quality Reporting System, visit the “[Educational Resources](#)” section of the [Physician Quality Reporting System](#) webpage.

- Additional material related to the Physician Quality Reporting System and eRx in today’s e-News... [\[previous\]](#)

### **New Webpage on CQMs Added to the EHR Website [\[↑\]](#)**

CMS has created a [new page](#) to the Electronic Health Record (EHR) [website](#) dedicated to the clinical quality measures (CQMs) and their role in the Medicare and Medicaid EHR Incentive Programs. The page intends to help providers better understand the purpose of CQMs and how to report on the measures.

The new CQM page of the website includes information on the following topics:

- General program definitions, like “Reporting Period”
- Eligible professional (EP) CQM reporting requirements
- Eligible hospital and critical access hospital (CAH) CQM reporting requirements
- Information on the CQM Pilot Program
- Resources and additional information on CQMs

You can also find helpful CQM resources on the new page, including the [Guide to CQMs](#) and a [webinar video](#) that provides an overview of the measures. Also be sure to review the [CQM EP Reporting Table](#) and the [CQM Eligible Hospital and CAH Reporting Table](#). Each document lists the CQMs for the Medicare and Medicaid EHR Incentive Programs for 2011-2012.

*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.

### **Extended Deadline for CMS Technical Expert Panel Nominations: Quality Measure Development and Maintenance for Coronary Artery Bypass Grafting and Cardiac Disease Prevention and Care [\[↑\]](#)**

CMS has contracted with Quality Insights of Pennsylvania to develop and maintain clinical quality measures for the Physician Quality Reporting System. Quality Insights is currently recruiting two Technical Expert Panels (TEPs) addressing Cardiovascular Disease, including:

- Coronary Artery Bypass Grafting (CABG)
- Cardiac Disease Prevention and Care

The purpose of this project is to develop and maintain measures used to support quality care to Medicare beneficiaries. Each of the Technical Expert Panels will advise Quality Insights on the continuing development and maintenance of existing clinical quality measures for the above-listed topics. Information and instructions about these TEPs may be at [http://www.CMS.gov/MMS/15\\_TechnicalExpertPanels.asp](http://www.CMS.gov/MMS/15_TechnicalExpertPanels.asp).

*Nominations for the TEPs are due by 5pm ET on Fri Feb 17.*

## **It's Not Too Late to Give and Get the Flu Vaccine** [[↑](#)]

Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention also recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at [http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10\\_VaccinesPricing.asp](http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp). Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit [http://www.CMS.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp) and <http://www.CMS.gov/immunizations>.

## **CMS Furnishes List of Off-The-Shelf Orthotic Healthcare Common Procedures Coding System Codes** [[↑](#)]

On Thu Feb 9, the Centers for Medicare & Medicaid Services (CMS) issued guidance that initially identifies specific Healthcare Common Procedure Coding System (HCPCS) codes that are considered Off-The-Shelf (OTS) orthotics.

Section 1847(a)(2) of the *Social Security Act* defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. Orthotics that are currently paid under section 1834(h) of the Act and described in section 1861(s)(9) of the Act are leg, arm, back, and neck braces.

The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 provides the longstanding Medicare definition of “braces” as “rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.” CMS regulations at 42 CFR 414.402 also define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.

To view the list of OTS orthotic HCPCS codes, please visit [http://www.CMS.gov/DMEPOSFeeSched/04\\_OT\\_Orthotics.asp](http://www.CMS.gov/DMEPOSFeeSched/04_OT_Orthotics.asp). Comments on the OTS list of codes may be submitted to CMS through Thu Mar 8.

## **Inpatient Psychiatric Facility Prospective Payment System FY2012 Pricer File Update** [[↑](#)]

The FY2012 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC Pricer has been updated with newer provider data, and is now available on the CMS website at [http://www.CMS.gov/PCPricer/09\\_inppsy.asp](http://www.CMS.gov/PCPricer/09_inppsy.asp). This Pricer is for claims dated from 10/01/2011 to 09/30/2012, and is dated 02/10/2012.

## **Inpatient Rehabilitation Facility Prospective Payment System FY2012 Pricer File Update** [[↑](#)]

The FY2012 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) PC Pricer has been updated with newer provider data, and is now available on the CMS website at [http://www.CMS.gov/PCPricer/06\\_IRF.asp](http://www.CMS.gov/PCPricer/06_IRF.asp). This Pricer is for claims dated from 10/01/2011 to 09/30/2012, and is dated 02/10/2012.

➤ Additional material related to Inpatient Rehabilitation Facilities in today's e-News... [\[previous\]](#)

### **Skilled Nursing Facility Prospective Payment System FY2012 PC Pricer Update** [\[↑\]](#)

The FY2012 Skilled Nursing Facility Prospective Payment System (SNF PPS) PC Pricer has been updated with newer provider data, and is now available on the CMS website at [http://www.CMS.gov/PCPricer/04\\_SNF.asp](http://www.CMS.gov/PCPricer/04_SNF.asp). This Pricer is for claims dated from 10/01/2011 to 09/30/2012, and is dated 02/10/2012.

### **From the MLN: New Fast Fact on MLN Provider Compliance Webpage** [\[↑\]](#)

A new fast fact is now available on the [MLN Provider Compliance](#) webpage. This webpage provides the latest Medicare Learning Network products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

### **From the MLN: “Updating Beneficiary Information with Coordination of Benefits Contractor” MLN Matters Article Released** [\[↑\]](#)

MLN Matters Special Edition Article #SE1205, “[Updating Beneficiary Information with the Coordination of Benefits Contractor](#),” has been released and is available in downloadable format. This article is designed to provide education on initiatives that CMS and the Coordination of Benefits Contractor (COBC) are undertaking to maintain accurate beneficiary Medicare Secondary Payer (MSP) information on Medicare’s Common Working File (CWF). It includes information that providers can use to understand how these initiatives will affect how they report beneficiary information to the COBC.

### **From the MLN: “Clinical Laboratory Fee Schedule” Fact Sheet Revised** [\[↑\]](#)

The “[Clinical Laboratory Fee Schedule](#)” fact sheet (ICN 006818) has been revised and is now available in downloadable format. This fact sheet includes background information as well as information coverage of clinical laboratory services and how payment rates are set.

### **From the MLN: MLN Provider Exhibit Program Schedule** [\[↑\]](#)

Just a reminder to mark your calendars! The Medicare Learning Network will be exhibiting at the following healthcare provider conferences in the coming weeks:

- [American College of Preventive Medicine](#)  
Wed Feb 22 through Sat Feb 25  
Orlando, Florida  
Booth #11
- [American Medical Group Association \(AMGA\) 2012 Annual Conference](#)  
Wed Mar 7 through Sat Mar 10  
Manchester Grand Hyatt; San Diego, California

- Booth #802
  - [American Medical Student Association](#)  
Thu Mar 8 through Sun Mar 11  
Hyatt Regency Houston; Houston, Texas  
Booth #12
- [National Association of Rural Health Clinics](#)  
Mon Mar 19 through Tue Mar 20  
Hyatt Regency; San Antonio, Texas
- [The American College of Cardiology's 61st Annual Scientific Session & Expo](#)  
Sat Mar 24 through Mon Mar 26  
Chicago, Illinois  
Booth #19076
- [National Hospice & Palliative Care Organization](#)  
Thu Mar 29 through Sat Mar 31  
National Harbor, MD  
Booth #625

Please make a note of these dates and locations and add them to your calendar! If you are interested in having a CMS Medicare Learning Network Exhibit at your event, contact us at [MLNexhibits@cms.hhs.gov](mailto:MLNexhibits@cms.hhs.gov).

#### More Helpful Links...

Check out CMS on



[Twitter](#), [LinkedIn](#), [YouTube](#), and [Flickr](#)!

**The Medicare Learning Network**

[www.CMS.gov/MLNGenInfo](http://www.CMS.gov/MLNGenInfo)

**Archive of Provider e-News Messages**

[www.CMS.gov/FFSProvPartProg/EmailArchive](http://www.CMS.gov/FFSProvPartProg/EmailArchive)