CMS Medicare FFS Provider e-News

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National Provider Call: PQRS and eRx Incentive Program Payment Adjustment — Last Chance to Register
Tuesday, June 18; 1:30-3pm ET

This National Provider Call provides a general overview on the Physician Quality Reporting System (PQRS) payment adjustment and the Electronic Prescribing (eRx) Incentive Program payment adjustment, as well as specifics on the 2015 PQRS and 2014 eRx adjustments, including eligibility, how to avoid future payment adjustments, key points, and tips for successful participation. This presentation also provides a list of resources and who to contact for help. A question and answer session follows the presentation.

Agenda:
- Announcements
- Presentation on PQRS and eRx Incentive Program payment adjustment
- Question and answer session

Target Audience: Eligible professionals, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all other interested Medicare FFS healthcare professionals

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 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 Information web page to learn more.

National Provider Calls: Medicare Shared Savings Program Application Process — Register Now
Thursday, June 20; 1:30-3pm ET— **Application Review**
Thursday, July 18; 1-2:30pm ET— **Application Question and Answer Session**

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program). This initiative will help providers participate in Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. CMS will host two National Provider Calls on the Shared Savings Program application process.

On Thursday, June 20, CMS subject matter experts will provide an overview and updates to the Shared Savings Program application process for the January 1, 2014 start date. A question and answer session will follow the presentations.

On Thursday, July 18, CMS subject matter experts will be available to answer questions about the Shared Savings Program and application process for the January 1, 2014 start date.

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

Target Audience: Medicare FFS providers

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 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.

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National Provider Call: Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology — Register Now

Thursday, June 27; 2:30-3:45pm ET

CMS and the Office of the National Coordinator for Health Information Technology (ONC) will provide an overview of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, including the use of certified EHR technology to meet meaningful use. Learn about the different types of certification and what certification actually tests.

Agenda:

- Overview of the EHR Incentive Programs
- ONC Health Information Technology (HIT) Certification Program
- 2014 Edition Testing and Certification
- Resources
- Question and answer with CMS and ONC experts

Target Audience: Eligible Professionals and Eligible Hospitals as defined by the Medicare and Medicaid EHR 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 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 Information web page to learn more.

National Provider Call: CMS National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open
Wednesday, July 10; 1:30-3pm ET

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 National Provider Call, CMS subject matter experts will discuss the progress that has been made during the implementation of this national partnership, its successes, and next steps. Additional speakers will share some personal success stories from the field. A question and answer session will follow the presentation.

Agenda:

- National partnership overview: Success through data
- Stories from the field: State coalitions, providers, clinicians
- Next Steps
  - Provider feedback
  - What outreach strategies have been successfully implemented and have led to meaningful change in nursing homes?
- Question and answer session

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

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

Presentation: The presentation for this call will be posted 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 Information web page to learn more.

National Provider Call: Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now
Wednesday, July 31; 2:30-3:30pm ET

This National Provider 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

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

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 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 Information web page to learn more.

National Provider Call: Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Save the Dates

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs paid out over $13.7 billion in incentives through March of this year. Don't be left out. CMS will be holding a series of National Provider Calls (NPCs) about different aspects of the EHR incentive programs. Don't miss these opportunities to learn from the experts.

Register now for the Certification call for Medicare and Medicaid Eligible Professionals on June 27.

Mark your calendars for these upcoming NPCs. Registration will be announced:

Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals:

- July 23; 1:30-3 —Clinical Quality Measures
- July 24; 1:30-3 —Stage 2

Medicare Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals

- August 13; 1:30-3 —Hardship Exceptions
- August 15; 1:30-3 —Payment Adjustments

PERM Cycle 2 Provider Education Webinar/Conference Calls

CMS is hosting Payment Error Rate Measurement (PERM) provider education webinar/conference calls for Medicare providers who also provide Medicaid and CHIP services. Complete details are available in the webinar/conference calls announcement.

Presentations will include:

- The PERM process and provider responsibilities during a PERM review
- Frequent mistakes and best practices
- The Electronic Submission of Medical Documentation, esMD program

To join the meeting:

- Registration is not required, however, space is limited
- All webinars are from 3-4pm ET
- Audio: 877-267-1577, Meeting ID# 4964
  - Tuesday, June 18 — Webinar
  - Tuesday, July 2 — Webinar
  - Wednesday, July 17— Webinar

New Medscape Module Available on EHRs in Practice: The Meaning of Meaningful Use

A new Medscape Module is now available on "EHRs in Practice: The Meaning of Meaningful Use." This roundtable discussion among Electronic Health Record (EHR) early adopters focuses on the requirements of Meaningful Use 1 and 2 and how their implementation can improve workflow and patient interactions. Physicians CME credits are available. To view the module, the person must be a registered Medscape user. There is no cost to join.

Medicare Urges Seniors to Join the Fight Against Fraud

New health care summaries help seniors identify improper payments

In mailboxes across the country, people with Medicare will soon see a redesigned statement of their claims for services and benefits that will help them better spot potential fraud, waste and abuse. These newly redesigned Medicare Summary Notices are just one more way the Obama Administration is making the elimination of fraud, waste and abuse in health care a top priority. Because of actions like these and new tools under the Affordable Care Act, the number of suspect providers and suppliers thrown out of the Medicare program has more than doubled in 35 states.

The redesigned notice will make it easier for people with Medicare to understand their benefits, file an appeal if a claim is denied, and spot claims for services they never received. CMS will send the notices to Medicare beneficiaries on a quarterly basis.

Medicare beneficiaries and caregivers are critical partners in the fight against fraud. In April of this year, CMS announced a proposed rule that would increase rewards— up to $9.9 million – paid to Medicare beneficiaries and others whose tips about suspected fraud lead to the successful recovery of funds.

Update on CMS Anti-Fraud Efforts

The Affordable Care Act has enabled CMS to expand efforts to prevent and fight fraud, waste and abuse. Over the last four years, the Obama administration has recovered over $14.9 billion in healthcare fraud judgments, settlements, and administrative impositions, including record recoveries in 2011 and 2012.

Since the Affordable Care Act, CMS has revoked 14,663 providers and suppliers' ability to bill in the Medicare program since March 2011. These providers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules.

In 18 states, the number of revocations has quadrupled since CMS put the Affordable Care Act screening and review requirements in place, as well as the implementation of proactive data analysis to identify potential license discrepancies of enrolled individuals and entities. These efforts are ensuring that only qualified and legitimate providers and suppliers can provide health care products and services to Medicare beneficiaries.

Full text of this excerpted CMS press release (issued June 6).

CMS Launches QAPI Website for Nursing Homes

New Quality Assurance and Performance Improvement (QAPI) materials are now available to help nursing homes establish a foundation to support and sustain QAPI. This is the first step in meeting the Patient Protection and Affordable Care Act requirement for CMS to develop a technical assistance program to help nursing homes establish best practices in quality. The following materials have been posted to the newly developed CMS nursing home QAPI website:

- QAPI at a Glance, a step-by-step guide for implementing QAPI
- Four process tools to help nursing homes start implementing QAPI
- QAPI News Brief – a newsletter describing QAPI principles which facilities can post for caregivers, residents and family members
- Nursing Home QAPI: What's in it for you? – A video introducing QAPI, its value to residents, their families and caregivers, and what is in it for nursing homes that embrace QAPI

CMS will continue to make additional QAPI tools, resources, and training materials available on the QAPI website for nursing home providers, along with materials to empower residents, their families, and advocates to be engaged in nursing home quality through this webpage, so check it often. Questions may be directed to Nhqapi@cms.hhs.gov.

HQRP Notification of Non-Compliance and Reconsideration Requests

To comply with Hospice Quality Reporting Program (HQRP) requirements impacting the annual payment update (APU) for FY 2014, hospice providers that had a valid CMS Certification Number (CCN) as of October 1, 2012 were required to submit data for the structural measure by January 31, 2013 and data for the NQF #0209 Pain Measure by April 1, 2013. Providers that were required to submit data but missed either deadline may be found non-compliant and subject to a 2 percentage point reduction in their APU for 2014. In June 2013, CMS will notify hospices that failed to meet the HQRP requirements. Providers who receive notification of non-compliance will have the opportunity to submit reconsideration requests, prior to any reduction in payment.

What to do if you receive notification of non-compliance:
Hospices that believe they have been erroneously identified as non-compliant may submit a request for reconsideration to CMS within *30 days* from the date of the notification of non-compliance. Any request for reconsideration must be accompanied by supporting documentation demonstrating compliance.

How to submit a reconsideration request:
Reconsideration requests must be sent to CMS via email. More detailed instructions on how to submit reconsideration requests can be found on the HQRP Reconsideration Requests web page.

Hospices may submit questions related to the reconsideration request requirements to: HospiceQRPReconsiderations@cms.hhs.gov.

CMS to Release Comparative Billing Report on Hospice Services — Target Release June 21

On June 21, 2013, CMS will release a national provider Comparative Billing Report (CBR) on Hospice Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in the state and across the nation.

These reports are only available to the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Hospice Services CBR, please visit the CBR Services website, or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30

A major Electronic Prescribing (eRx) Incentive Program deadline is approaching for both individual eligible professionals (EPs) and group practices participating in the Group Practice Reporting Option (GPRO). If you are an EP or an eRx GPRO participant, you must successfully report as an electronic prescriber before June 30, 2013 or you will experience a payment adjustment in 2014 for professional services covered under Medicare Part B's Physician Fee Schedule (PFS).

The 2013 eRx Incentive Program 6-month reporting period (January 1, 2013 to June 30, 2013) is the final reporting period available to you if you wish to avoid the 2014 eRx payment adjustment. If you do not successfully report, a payment adjustment of 2.0% will be applied, and you will receive only 98.0% of your Medicare Part B PFS amount for covered professional services in 2014.

Avoiding the 2014 eRx Payment Adjustment
Individual EPs and eRx GPRO participants who were not successful electronic prescribers in 2012 can avoid 2014 eRx payment adjustment by meeting specified reporting requirements between January 1, 2013 and June 30, 2013. Below are the 6-month reporting requirements:

- Individual EPs – 10 eRx events via claims

- eRx GPRO of 2-24 EPs – 75 eRx events via claims
- eRx GPRO of 25-99 EPs – 625 eRx events via claims
- eRx GPRO of 100+ EPs – 2,500 eRx events via claims

Exclusions and Hardships Exemptions
Exclusions from the 2014 eRx payment adjustment only apply to certain individual EPs and group practices, and CMS will automatically exclude those individual EPs and group practices who meet the criteria. CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2014 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship. Requests for hardship exemptions must be submitted by June 30, 2013. More information on exclusion criteria and hardship exemption categories can be found on the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Resources from CMS
To learn more about the eRx Incentive Program, please visit the CMS eRx Incentive Program website. Additional resources on the 2014 payment adjustment are available on the eRx Incentive Program Payment Adjustment Information web page, including the resource Electronic Prescribing (eRx) Incentive Program: Updates for 2013.

Questions about eRx?
If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. The Help Desk is available Monday through Friday from 7am-7pm CT.

PQRS Call for Measures Ends July 1

CMS is currently accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. CMS is seeking a quality set of measures that are outcome-based and fall into one of the National Quality Strategy (NQS) Priorities domains where there are known measure and performance gaps. The measure gaps that CMS most wishes to fill include clinical outcomes, patient-reported outcomes, care coordination, safety, appropriateness, efficiency, and patient experience and engagement.

Measures submitted for consideration will be assessed to ensure that they meet the needs of the Physician Quality Reporting Program. In addition, CMS encourages eligible providers to submit measures that do not have an adequate representation within the program for participation. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Suggested measures must address the CMS measure selection core criteria listed on the Measures Management System Call for Measures web page to be considered for inclusion in the PQRS.

Each measure must be submitted in the required format must include all required supporting documentation to be accepted for consideration. The Measures Submitted for Consideration Excel Form is posted on the Measures Management System Call for Measures web page. Please note that full specifications are not requested at this time. When the Call for Measures closes, CMS will review all of the submitted measures to determine those that will move forward. For selected measures, measure stewards will be asked to provide full specifications.

This Call for Measures runs from May 1 through July 1, 2013. Completed documentation must be submitted electronically to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov no later than 5pm ET on July 1, 2013. Questions about this Call for Measures or the required documentation may be submitted to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the PQRS. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs

July 3, 2013 is last day that eligible hospitals and critical access hospitals (CAHs) in their first year of participation of the Medicare EHR Incentive Program can begin their 90-day reporting period to demonstrate meaningful use for FY 2013. Hospitals in their second and third years of participation must demonstrate meaningful use for the full FY.

Looking Ahead
Three other important dates for eligible hospitals and CAHs include:
- September 30, 2013—Last day of FY 2013, and the end of the reporting year.
- October 1, 2013—First day of FY 2014, and the start of Stage 2 for hospitals in their third or fourth years of participation.
- November 30, 2013—Last day to register and attest to receive an incentive payment for FY 2013.

See other 2013 important dates in the 2012-2014 Health Information Technology timeline.

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.

CMS has Released Updated Resources with Changes to Stage 1 Meaningful Use Objectives, Measures, and Exclusions

Changes to Stage 1 Measures
Beginning in 2013, there are several changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs' Stage 1 meaningful use objectives, measures, and exclusions. These changes took effect on October 1, 2012, for eligible hospitals and critical access hospitals (CAHs), and on January 1, 2013, for eligible professionals (EPs). Although some of the changes to meaningful use objectives, measures, and exclusions are optional, others are required.

Stage 1 Changes Resources
In order to help providers understand the changes to Stage 1 of meaningful use, CMS has released several resources with detailed information on the affected sections of the program.
- 2013 Stage 1 Changes Tip Sheet — Explains the changes for the 2013 program year and which providers are affected
- Updated Stage 1 Specification Sheet Table of Contents for EPs and for eligible hospitals and CAHs — lists all the Stage 1 core and menu objectives, with direct links to each individual measure specification sheet

- Updated Stage 1 Specification Sheet zip files for EPs and for eligible hospitals and CAHs — contain PDFs for download of all of the core and menu objectives for EPs and eligible hospitals and CAHs

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.

Correction to "DMEPOS Competitive Bidding Round 2 Transitional Policy — CPAP Device Documentation Requirements" From June 6 e-News

Last week, the e-News contained an article titled "DMEPOS Competitive Bidding Round 2 Transitional Policy — CPAP Device Documentation Requirements." Please disregard that article as updated instructions regarding the grace period will be provided by CMS soon.

July 2013 Average Sales Price Files Now Available

CMS has posted the July 2013 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on the 2013 ASP Drug Pricing Files web page.

Inpatient Prospective Payment System PC Pricer Updated

The FY 2013 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with transfer claim logic fixes. The latest version is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

June 2013 Version of the "Medicare Learning Network (MLN) Products Catalog" — Now Available

The June 2013 version of the "MLN Products Catalog" is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available."

From the MLN: The "Annual Wellness Visit" Podcast — Released

The "Annual Wellness Visit" Podcast (ICN 908726) was released and is now available in downloadable format. This podcast is designed to provide education on the Annual Wellness Visit (AWV) which provides personalized preventive plan services. It includes information on initial and subsequent AWVs as well as health risk management information.

From the MLN: "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet — Revised

The "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet (ICN 903766) was revised and is now available in downloadable format. This fact sheet is

designed to provide contact information for technical assistance with Internet-based PECOS. It includes a list of contacts and other resources.

From the MLN: "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record" Fact Sheet — Revised

The "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record" Fact Sheet (ICN 903765) was revised and is now available in downloadable format. This fact sheet is designed to provide education on how to ensure Medicare enrollment records are up-to-date and secure. It includes information on the actions physicians and non-physician practitioners should take to protect their Medicare enrollment information.

From the MLN: "The Medicare Dependent Hospital" Fact Sheet — Revised

The "Medicare Dependent Hospital" Fact Sheet (ICN 901683) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Medicare Dependent Hospitals (MDH). It includes the following information: classification criteria and MDH payments.

From the MLN: "The Medicare Billing Certificate Program for Part A Providers" and "The Medicare Billing Certificate Program for Part B Providers" Web-Based Training Programs — Revised

"The Medicare Billing Certificate Program for Part A Providers" Web-Based Training Program is revised and is now available. This WBT is designed to provide education on Part A of the Medicare program. It includes required web-based training courses and readings and a helpful list of resources. Upon successful completion of this program, you will receive a certificate in Medicare billing for Part A providers from CMS.

"The Medicare Billing Certificate Program for Part B Providers" Web-Based Training Program is revised and is now available. This WBT is designed to provide education on Part B of the Medicare program. It includes required web-based training courses and readings and a helpful list of resources. Upon successful completion of this program, you will receive a certificate in Medicare billing for Part B providers from CMS.

To access these WBTs, go to MLN Products and click on "Web-Based Training Courses" under "Related Links" at the bottom of the web page.

From the MLN: Pilot Testers Needed

Are you interested in pilot testing Medicare Learning Network® (MLN) web-based training courses, reviewing MLN publications, and providing your feedback? If so, please e-mail CMSCE@cms.hhs.gov with your name, occupation, state of residence, and e-mail address. You will receive a confirmation e-mail that you have been added into our database. Thank you for volunteering your time and expertise.

MLN Learning Management System New Password Requirements

Effective Thursday June 13, 2013, when you log into the MLN Learning Management System (LMS) you will be prompted to change your password so it complies with the new password requirements. Your LMS password must comply with the following requirements:

- at least eight characters,
- at least one number,
- one lower case letter,
- one upper case letter,
- and one of the following symbols: ! @ $ % & ?

No spaces are allowed, and you may not use any of your last six passwords as your new password. Your new password will be case sensitive and effective the next time you log into the site.

These changes will help protect your LMS account and provide you with a more secure user experience. Please send any questions to MLN@cms.hhs.gov.

CMS asks that you share this important information with interested colleagues and recommends they subscribe to receive the *e-News* directly.

Previous issues are available in the archive.

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