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## 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!**

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- [“Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors” MLN Matters® Article Revised](#)
- [“The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Accreditation” Fact Sheet Revised](#)
- [“Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Information for Pharmacies” Fact Sheet Revised](#)
- [“A Physician’s Guide to Medicare’s Home Health Certification, including the Face-to-Face Encounter” MLN Matters® Article Released](#)
- [Needed: Physician Pilot Testers](#)

**National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now** [[↑](#)]

*Wednesday, May 16; 2-3:30pm ET*

CMS is hosting a National Provider Call regarding the current status of Medicare FFS implementation of HIPAA Version 5010 and D.0. This National Provider Call will address the current 5010/D.0 metrics, and discuss recommendations made by Medicare FFS, and possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

*Target Audience:* Vendors, clearinghouses, and providers who need to make Medicare FFS specific changes in compliance with HIPAA Version 5010 requirements.

*Agenda:*

- Current 5010/D.0 metrics
- Addressing recommendations made by Medicare FFS
- Possible outstanding fixes impacting the Part A and Part B Version 5010 transition
- Q&A session

*Registration Information:* In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls webpage](#). 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 at least one day in advance on the [FFS National Provider Calls webpage](#). In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

**National Provider Call — Physician Quality Reporting System & Electronic Prescribing (eRx) – Register Now** [[↑](#)]

*Tuesday, May 22; 1:30-3pm ET*

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the 2013 Electronic

Prescribing Payment Adjustment and an overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot.

*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 the 2013 Electronic Prescribing Payment Adjustment
- Overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot
- Question & Answer Session

*Registration Information:* In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls webpage](#). 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 at least one day in advance on the [FFS National Provider Calls webpage](#). In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

- Additional material related to electronic prescribing in today's e-News [[next](#)]

### **National Provider Call — Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements – Register Now [↑](#)**

*Thursday, May 31; 2-3:30 pm ET*

Beginning January 1, 2010, all Medicare Fee-For-Service (FFS) inpatient rehabilitation facility (IRF) claims were required to meet new coverage requirements for payment under the IRF prospective payment system (PPS). During this National Provider Call, CMS subject matter experts will provide an overview of the requirements and address questions that providers continue to have as they apply these requirements. Don't miss this opportunity to participate in updated training on the IRF PPS coverage requirements.

*Target Audience:* Medicare FFS providers, IRF providers, Recovery Audit Contractors, and Medicare Administrative Contractors

*Registration Information:* In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls webpage](#). 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 at least one day in advance on the [FFS National Provider Calls webpage](#). In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

## **Video Slideshow Presentation and Podcasts from March 1 National Provider Call on the Medicare Shared Savings Program and Advance Payment Model Application Process Now Available [\[↑\]](#)**

CMS has released a YouTube video slideshow presentation and podcasts from the March 1, 2012 Medicare Shared Savings Program and Advance Payment Model Application Process National Provider Call.

### *YouTube Video Slideshow Presentation*

The call presentation is now available on the [CMS YouTube Channel](#) as a video slideshow that includes the call audio.

### *Podcasts*

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available on the [National Provider Calls and Events March 1, 2012](#) detail page.

- Podcast 1 of 3: Medicare Shared Savings Program Application Process
- Podcast 2 of 3: Advance Payment Model Application Process
- Podcast 3 of 3: Question and Answer Session

Select the links above to view the video slideshow presentation and listen to the podcasts, or visit the [National Provider Calls and Events March 1, 2012](#) detail page for access to all of the related call materials, including the slide presentation, full audio recording, and written transcripts.

- Additional material related to the Medicare Shared Savings Program in today's e-News [\[next\]](#)

## **May is National Osteoporosis Month [\[↑\]](#)**

Osteoporosis is common, serious, and costly — and it can lead to an increased risk of bone fractures, typically in the wrist, hip, and spine. Often called a silent disease because bone loss occurs without symptoms, people may not know that they have osteoporosis until their bones become so weak that a sudden bump or fall causes a fracture. Please join with CMS in continuing to honor women this month by helping to raise awareness of osteoporosis and the importance of prevention and early detection in combating this disease.

### *Did You Know?*

- About 10 million Americans have osteoporosis, and about 34 million more are at risk.
- One out of every 2 women and 1 in 4 men aged 50 and older will have an osteoporosis-related fracture in their lifetime.
- Twenty-four percent of hip fracture patients age 50 and older die in the year following their fracture.

While men and women of all ages and ethnicities can develop osteoporosis, certain risk factors are linked to the development of osteoporosis and contribute to an individual's likelihood of developing the disease.

- *Gender* – Women have a greater chance of developing osteoporosis due to less bone tissue and changes that occur due to menopause.
- *Ethnicity* – Caucasian and Asian women are at highest risk. African American and Hispanic women have lower but significant risk.
- *Age* – Older adults have greater risk of osteoporosis because bones become thinner and weaker with age.
- *Body size* – Small, thin-boned women are at greater risk.

- *Diet* – An inadequate intake of calcium and vitamin D over a lifetime makes an individual more prone to bone loss and contributes to the development of osteoporosis.
- *Lifestyle* – An inactive lifestyle or extended bed rest tends to weaken bones.
- *Family history* – Fracture risk may be due, in part, to heredity.
- *Smoking* – Women who smoke have lower levels of estrogen compared with nonsmokers, often go through menopause earlier, and may also absorb less calcium from their diets.
- *Medication use*. Long-term use of certain medications can lead to loss of bone density and fractures.
- *Alcohol* – Those who drink heavily are more prone to bone loss and fracture, because of poor nutrition and increased risk of falling.

People with osteoporosis may have several risk factors, while others who develop the disease may have no known risk factors at all.

Osteoporosis is a preventable and treatable disease. Early diagnosis and treatment can reduce or prevent fractures. Medicare provides coverage of bone mass measurement for certain eligible beneficiaries. This important benefit can aid in the early detection of osteoporosis before fractures happen, provide a precursor to future fractures, and determine the rate of bone loss. Please help ensure that eligible Medicare patients utilize this benefit as it can help make a difference in the quality of their life.

*For More Information:*

- [CMS MLN Guide to Medicare Preventive Services](#) (see Chapter 14)
- [CMS Bone Mass Measurements brochure](#)
- [NIH Osteoporosis and Related Bone Diseases National Resource Center](#)
- [National Osteoporosis Foundation website](#)

### **We Can't Wait: HHS Announces First 26 Health Care Innovation Awards** [[↑](#)]

*Programs Will Save Estimated \$254 Million, Improve Health Care*

On May 8, HHS Secretary Kathleen Sebelius announced the first batch of organizations for Health Care Innovation awards. Made possible by the health care law – the Affordable Care Act – the awards will support 26 innovative projects nationwide that will save money, deliver high quality medical care, and enhance the health care workforce. The preliminary awardees announced today expect to reduce health spending by \$254 million over the next 3 years.

The new projects include collaborations of leading hospitals, doctors, nurses, pharmacists, technology innovators, community-based organizations, and patients' advocacy groups, among others, located in urban and rural areas that will begin work this year to address health care issues in local communities. This initiative allows applicants to come up with their best ideas to test how we can quickly and efficiently improve the quality and affordability of health care.

Preliminary awardees were chosen for their innovative solutions to the health care challenges facing their communities and for their focus on creating a well-trained health care workforce that is equipped to meet the need for new jobs in the 21<sup>st</sup> century health system. The Bureau of Labor Statistics projects the health care and social assistance sector will gain the most jobs between now and 2020.

Today's awards total \$122.6 million. The Center for Medicare and Medicaid Innovation within CMS at HHS administers the awards through cooperative

agreements over 3 years.

For more information on the awards announced today, go to the [Healthcare Innovation Awards webpage](#). Learn more about other innovative models being tested on the [CMS Innovation Center webpage](#).

Full text of this excerpted [CMS press release](#) (issued May 8).

### **There is only 1 week to Submit Comments for the HHS Proposed Rule to Delay ICD-10 [\[↑\]](#)**

The [proposed rule](#) to delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014 is posted to the Federal Register. *There is only one week left in the 30-day comment period.* This comment period allows you to provide very important feedback to HHS about this proposed compliance date change, which will affect many aspects of your organization.

When proposing the delay to ICD-10, HHS took into consideration feedback that some provider groups have concerns about their ability to meet the October 1, 2013 ICD-10 compliance date, based in part on implementation issues they have experienced meeting HHS' compliance deadline for Version 5010 standards.

All HIPAA-covered entities must transition to ICD-10 in order to assure that there is a smooth transition between provider organizations and trading partners, which will help to avoid rejected claims and provider payment delays. By delaying the compliance date for ICD-10, as proposed in this rule, providers and other covered entities will have more time to prepare and fully test their systems to ensure a smooth and coordinated transition among all industry segments.

All comments are due to HHS no later than 5:00 pm ET on May 17, 2012, and can be submitted in the following ways:

- Electronically by following the "Submit a comment" instructions on the [Regulations.gov website](#)
- By regular mail sent to:  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-0040-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

### *Keep Up to Date on Version 5010 and ICD-10*

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

### **New Data Provides Info on EPs who Participated in the Medicare EHR Incentive Program in 2011 [\[↑\]](#)**

CMS has posted the [2011 Medicare Electronic Health Record \(EHR\) Incentive Program Eligible Professionals Public Use File \(PUF\)](#) to the EHR website. This new file contains data on Eligible Professionals (EPs) who participated in the Medicare EHR Incentive Program in 2011.

The CMS 2011 Medicare EHR Incentive Program Eligible Professionals PUF provides detailed information about EPs who attested as of December 22, 2011, including each provider's type, specialty, and his/her responses to the meaningful use core and menu measures. The PUF excludes data from hospitals in the Medicare EHR Incentive Program, which will be posted at a later date. There is no 2011 data available for participants in the Medicaid EHR Incentive Program, who received incentive payments in 2011 only for adopting, implementing, or upgrading to certified EHR technology.

Additional information on the PUF can be found on the [Data and Reports page](#) of the EHR website.

*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.

### **Submit Your Medicare Enrollment Application Up to 60 Days Before the Effective Date** [[↑](#)]

Providers and suppliers can now submit their enrollment applications 30 days sooner. CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date.

*NOTE: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSSs).*

### **Were You Sent a Request to Revalidate Your Medicare Enrollment?** [[↑](#)]

At this time, the quickest way to see if a revalidation letter was mailed to you is to check the “Downloads” on the [Revalidation page](#) on the cms.gov website. You can now view:

- [Medicare Part A/B Revalidation Letters Mailed February - March 2012](#)
- [Medicare Part A/B Revalidation Letters Mailed January 2012](#)
- [Medicare Part A/B Revalidation Letters Mailed November - December 2011](#)
- [Medicare Part A/B Revalidation Letters Mailed September - October 2011](#)
- [NSC Revalidation Letters Mailed](#)

Later this year, CMS plans to implement a faster process for allowing users to see the date the revalidation notice was sent directly on the “My Enrollments” page within PECOS.

### **Medicare Enrollment/Revalidation: Requests for the IRS Form CP 575** [[↑](#)]

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter you receive from the IRS granting your Employer Identification Number (EIN). A copy of your CP 575 may be required by the Medicare contractor to verify the provider or supplier's legal business name and EIN.

*When is the CP 575 is required to be submitted to the Medicare contractor?*

- If the applicant is enrolling as a professional corporation, professional association, or limited liability corporation
- If the applicant is enrolling as a sole proprietor using an EIN
- If the Medicare contractor determines a discrepancy between the provider or supplier's legal business name and EIN provided in Section 2 of the CMS-855 form
- The CP 575 May be requested by the CMS External User Services (EUS) Help Desk, for verification, when the Authorized Official (AO) of the provider or supplier organization registers for Internet-based PECOS access.

If you do not have a form CP 575: contact the IRS on 1-800-829-4933 from 7am to 7pm.

### **Submit a Notice of Intent to Apply for the Medicare Shared Savings Program January 1, 2013 Start Date – Due by June 15 [\[↑\]](#)**

If you are interested in applying for participation for the January 1, 2013 start date of the Medicare Shared Savings Program, please submit a Notice of Intent to Apply *by June 15, 2012*. For more information, visit the [Shared Savings Program Application webpage](#).

### **Payment Delay Affecting Inpatient Hospital and Skilled Nursing Facility Claims [\[↑\]](#)**

CMS is aware of a systems problem that is delaying payment of some inpatient and Skilled Nursing Facility (SNF) claims processed beginning April 2. The systems issue has been fixed and payments for these claims will be made soon. Providers that believe their claims have been delayed should check the claims status after May 15. CMS apologizes for the inconvenience.

### **Medicare Electronic Prescribing Payment Adjustment Hardship Exemption [\[↑\]](#)**

In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0% in 2012, 1.5% in 2013, and 2.0% in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0%, 98.5%, and 98.0% respectively of their Medicare Part B PFS amount for covered professional services.

#### *Exclusion Criteria*

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following criteria:

- The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy

- code in the National Plan and Provider Enumeration System (NPPES).
- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

#### *Avoiding the 2013 eRx Payment Adjustment*

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

#### *6-month Reporting Requirements to Avoid the 2013 Payment Adjustment:*

- Individual Eligible Professionals – 10 eRx events via claims
- Small eRx GPRO – 625 eRx events via claims
- Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please see the [MLN Article SE1206 - 2012 Electronic Prescribing \(eRx\) Incentive Program: Future Payment Adjustments](#).

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

#### *Significant Hardships*

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

#### *Submitting a Significant Hardship Code or Request*

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the [Quality Reporting Communication Support Page](#) (Communication Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1 through June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For more information on how to navigate the [Communication Support Page](#), please reference the following documents:

- [Quality Reporting Communication Support Page User Guide](#)
- [Tips for Using the Quality Reporting Communication Support Page](#)

For additional information and resources, please visit the [E-Prescribing Incentive Program webpage](#).

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 877-715-6222) or via [qnetssupport@sdps.org](mailto:qnetssupport@sdps.org). They are available Monday through Friday from 7am to 7pm CST.

**Correction: Spotlight Women’s Health in May in Recognition of Women’s Health Week, and Women’s Checkup Day** [[↑](#)]

In last week’s issue of the [e-News](#), an incorrect link to The Centers for Disease Control and Prevention Women’s Health Website was given. CMS regrets this error.

- [The Centers for Disease Control and Prevention Women’s Health Website](#)

**Medicare Fee-For-Service Part A Common Edit and Enhancements Module Editing Clarification** [[↑](#)]

This is a clarification that Medicare Fee-For-Service (FFS) Part A edits (277CA, 999, and TA1) produced via the ASC X12 Version 5010 Common Edit and Enhancements Module (CEM) are not correctable using Direct Data Entry (DDE). The errors that cause a TA1, 999 or 277CA result in a rejected claim, which means the claim never reaches the DDE process. CEM edits must be corrected by submitting another 5010 837 institutional transaction.

For more information on Version 5010, NCPDP D.0, and NCPDP 3.0; please visit the [Versions 5010 and D.0 website](#).

**Inpatient Prospective Payment System PC Pricer Updated** [[↑](#)]

The Fiscal Year (FY) 2012 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with newer provider data. The latest version is now available on the [Inpatient PPS PC Pricer website](#) in the “Downloads” section. This PC Pricer is for claims dated from October 1, 2011 to September 30, 2012.

**From the MLN: “Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors” MLN Matters® Article Revised** [[↑](#)]

[MLN Matters® Article #MM6417](#), “Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)” article has been revised to reference [MLN Matters® Article SE1201](#). These articles contain important information on the requirements for billing for ordered and referred services. Also remember that CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin.

**From the MLN: “The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation” Fact Sheet Revised** [[↑](#)]

[The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Accreditation](#) Fact Sheet (ICN 905710) has been revised and is now in downloadable and hard copy format. This fact sheet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (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.

**From the MLN: “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies” Fact Sheet Revised** [[↑](#)]

[Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Information for Pharmacies](#) Fact Sheet (ICN 905711) has been revised and is now available in downloadable and hard copy format. This fact sheet is designed to provide education for pharmacies on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes information on accreditation by CMS-approved independent national Accreditation Organization (AO) as well as information if a pharmacy wants to be considered for an exemption from the accreditation requirements.

**From the MLN: “A Physician’s Guide to Medicare’s Home Health Certification, including the Face-to-Face Encounter” MLN Matters® Article Released** [[↑](#)]

[MLN Matters® Special Edition Article #SE1219](#), “A Physician’s Guide to Medicare’s Home Health Certification, including the Face-to-Face Encounter” is now available in downloadable format. This article is designed to provide education to physicians on requirements for the home health certification and face-to-face encounter. It includes milestones and requirements that must be met to perform Physician Home Health face-to-face encounters, certifications, and recertifications. A link to frequently asked questions about the Home Health Face-to-Face Encounter is also included.

**Needed: Physician Pilot Testers** [[↑](#)]

The Certificate of Medical Necessity (CMN) Web-Based Training (WBT) course is ready to be pilot tested. If you are a physician and are interested and available to pilot test during the month of May, please send an email to [CMSMLN.PILOTTESTING@palmettogba.com](mailto:CMSMLN.PILOTTESTING@palmettogba.com) by May 18, and in the “Subject” field put "Volunteer Pilot Tester."

#### 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)