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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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The e-News for Wednesday, May 16, 2012

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- [“Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Quality Standards” Booklet Revised](#)
- [“Quick Reference Information: Preventive Services” and “Quick Reference Information: Medicare Immunization Billing” Revised](#)
- [“Medicare Fraud & Abuse: Prevention, Detection, and Reporting” Web-Based Training — New](#)

National Provider Call — Physician Quality Reporting System & Electronic Prescribing (eRx) – Last Chance to Register [\[↑\]](#)

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.

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.

May is Hepatitis Awareness Month and May 19 is National Hepatitis Testing Day [\[↑\]](#)

The month of May has been designated [Hepatitis Awareness Month](#) and May 19 is the first ever [National Hepatitis Testing Day](#). Every year, approximately 15,000 Americans die from liver cancer or chronic liver disease associated with viral hepatitis. Despite this, viral hepatitis is not well known. In fact, as many as 75 percent of

the millions of Americans with chronic viral hepatitis don't know they're infected. Please join CMS in support of the Centers for Disease Control and Prevention's "Know More Hepatitis" national education initiative aimed to decrease the burden of chronic viral hepatitis by increasing awareness about this hidden epidemic and encouraging people who may be chronically infected to get tested.

Medicare provides coverage of the hepatitis B vaccine and its administration for certain individuals at high or intermediate risk.

Increased provider knowledge has been shown to improve delivery of preventive services, including those for viral hepatitis. By educating yourself on this hidden epidemic, you can help save lives and decrease this epidemic's burden. As a healthcare provider for people with Medicare, discuss with eligible patients who may be at high or intermediate risk, whether the hepatitis B vaccine is appropriate.

CMS MLN Resources for Health Care Professionals:

- [The Guide to Medicare Preventive Services, Fourth Edition, Chapter 5](#)
- [The Preventive Immunizations Brochure](#)
- [Quick Reference Information: Medicare Immunizations Billing Chart](#)
- [Preventive Services Educational Products](#)

HHS Finalizes New Rules to Cut Regulations for Hospitals and Health Care Providers, Savings More Than \$5 Billion [\[↑\]](#)

Changes Will Reduce Costs and Allow More Focus on Medical Care

On May 9, HHS Secretary Kathleen Sebelius announced significant steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save nearly \$1.1 billion across the health care system in the first year and more than \$5 billion over five years.

The new rules were issued on May 9 by CMS. The first rule revises the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). CMS estimates that annual savings to hospitals and CAHs will be approximately \$940 million per year.

The second, the Medicare Regulatory Reform rule, will produce savings of \$200 million in the first year by promoting efficiency. This rule eliminates duplicative, overlapping, and outdated regulatory requirements for health care providers.

Among other changes, the final rules will:

- Increase flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system;
- Let CAHs partner with other providers so they can be more efficient and ensure the safe and timely delivery of care to their patients;
- Require that all eligible candidates, including advanced practice registered nurses and physician assistants, be reviewed by medical staff for potential appointment to the hospital medical staff and then be granted all of the privileges, rights, and responsibilities accorded to appointed medical staff members; and
- Eliminate obsolete regulations, including outmoded infection control instructions for ambulatory surgical centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of organ procurement organizations.

View the [Medicare CoPs final rule](#) and the [Medicare Regulatory Reform final rule](#). For additional information on the Hospital and other CoPs, visit the [Conditions for Coverage \(CfCs\) & Conditions of Participations \(CoPs\) website](#).

Full text of this excerpted [CMS press release](#) (issued May 9).

CMS Has Posted Information on Recipients of Medicare EHR Incentive Program Payments [\[↑\]](#)

In compliance with the HITECH Act's requirement, CMS has posted the names, business phone numbers, and business addresses of Medicare eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that have successfully demonstrated meaningful use and received a payment as of March 2012. Medicare EPs, eligible hospitals, and CAH's were able to verify and edit their business phone numbers and addresses during the registration process. CMS has not posted information on group practices, as incentive payments are not provided at the group practice level.

Beginning this month, CMS is posting two file formats of Medicare EHR Incentive Program payment recipients. One format is a searchable PDF, and the other is a tabular downloadable CSV file that can be opened in many common spreadsheet programs. This CSV file can also be used to sort information about recipients, for example, by medical specialty or the state in which they practice. Use the links below to access the PDF and CSV files.

CSV Files

- [EP Recipients of Medicare EHR Incentive Program Payments](#)
- [Hospital Recipients of Medicare EHR Incentive Program Payments](#)

PDF Files

- [EP Recipients of Medicare EHR Incentive Program Payments](#)
- [Hospital Recipients of Medicare EHR Incentive Program Payments](#)

Please Note:

These lists will be updated on a quarterly basis. Not all providers are eligible for the Medicare EHR Incentive Program. Only those professionals, hospitals, and CAHs that are eligible based on the regulation's [eligibility requirements](#), attested to meaningfully using an EHR, and have received a Medicare incentive payment will be displayed online. Finally, the Act does not require CMS to post the names of eligible professionals, eligible hospitals and CAHs that have received Medicaid EHR Incentive Program payments.

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.

Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade [\[↑\]](#)

Upgrading to [Version 5010](#) involves significant planning and preparation. The Version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, CMS enacted an enforcement discretion period through June 30, 2012 for all HIPAA-covered entities. If you haven't upgraded to Version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-health Standards & Services (OESS) recently took time to answer some of the industry's top questions on the Version 5010 upgrade.

1. Is the industry up to date with the Version 5010 upgrade and taking steps to prepare for the ICD-10 transition?
Yes, we are hearing that the industry is progressing with Version 5010 implementation. We also continue to see from the Medicare Fee-For-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. We are also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for

organizations that plan ahead and prepare now. A successful upgrade to Version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.

2. What steps should I take if I am behind in the upgrade to Version 5010?

There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

- Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
- Check with payers now to see what plans they will have in place to handle incoming claims, and what interim alternatives are available.
- Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being Version 5010 compliant.

CMS has developed a [fact sheet](#) for health care providers, which discusses the risk mitigation steps in more detail.

3. How is CMS helping the industry prepare?

- The Workgroup for Electronic Data Interchange (WEDI) and CMS are holding a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30pm ET. [Registration](#) is free. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.
- WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a [replay](#) of the webinar with the slides presented is located online.
- Additionally, the [CMS website](#) has official resources to help the industry prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for [ICD-10 Email Updates](#) and follow @CMSgov on [Twitter](#) for the latest news and resources.

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.

CMS Will Begin Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups [[↑](#)]

CMS will be accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures, visit the [CMS Measures Management System webpage](#).

For measures to be considered into the Physician Quality Reporting System, please provide the required documentation for each measure submitted for consideration beginning *June 1, 2012* and no later than *5pm ET August 1, 2012*.

Required documentation includes the Measure Submitted for Consideration Form, measure specifications (measure title, description, numerator, and denominator, including exclusions, exceptions, and inclusions), and electronic specification and data tables for Electronic Health Record (EHR)-specified candidate measures.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the Physician Quality Reporting System. CMS will determine what 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 Physician Quality Reporting System.

On April 19, 2012, CMS released an enhancement of the Physician Compare website. Improvements were based on recommendations made during testing as well as suggestions from users and stakeholders. This release is part of ongoing effort to improve Physician Compare.

New Group Practice Option

Physician Compare has a new Group Practice option including [Search](#), [Compare](#) and [Profile](#) pages. The new features allow users to search by Group Practice name, get maps and directions, and do side-by-side comparisons of Group Practices.

The Group Practice pages are ready for you to preview now. Please take a few moments to evaluate the overall look and feel of the pages as well as the way the Group Practice search operates, as this will be the platform for sharing quality of care data when they become available. Once you review the pages, please let us know what you think by sending an email to PhysicianCompare@Westat.com.

CMS will continue to inform you about future releases and updates to the Physician Compare website, and we look forward to reviewing your feedback.

Additional Information on Home Health Face-to-Face Encounter Requirements [\[↑\]](#)

On May 7, CMS released an [MLN article](#) designed to provide education on the contents of the home health certification, including homebound criteria and requirements for the face-to-face encounter and documentation. It includes guidance that physicians, non-physician practitioners, physician support personnel, and home health agencies can use to ensure that all certification requirements are understood and met. In addition, on May 4, updated face-to-face encounter [Questions & Answers](#) were posted and are available through the [CMS Home Health Agency \(HHA\) spotlight page](#).

CMS to Release a Comparative Billing Report on Evaluation and Management Services — Target Release June 4 [\[↑\]](#)

On June 4, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

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

These reports are not available to anyone except 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 Evaluation and Management Services CBR, please visit the [CBR Services website](#) or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Prior Authorization Demonstration Update [\[↑\]](#)

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven

states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. This demonstration will begin Summer 2012.

To read more about the demonstration, visit the [Prior Authorization of Power Mobility Devices \(PMD\) Demonstration webpage](#). Stakeholders may submit questions to PAdemo@cms.hhs.gov<<mailto:PAdemo@cms.hhs.gov>>.

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 gnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.

Home Health Claims Selected for Review with Dates of Service October 1, 2011 through December 31, 2011 [[↑](#)]

CMS issued V3210 of the home health (HH) prospective payment system (PPS) Grouper effective for dates of service October 1, 2011 and later. New Diagnosis codes 294.20 and 294.21 were not initially approved for addition to the V3210 of the HH PPS Grouper. In V3312, CMS has added these two diagnosis codes for dates of service October 1, 2011 and later. V3312 of the HH PPS Grouper which is effective January 1, 2012 will update the HH PPS Grouper so that OASIS records submitted with these diagnosis codes will result in the HH PPS Grouper producing the appropriate set of scores and HIPPS code for dates of service October 1, 2011 and later.

Regional Home Health Intermediaries (RHHIs) have received technical direction from CMS that provides the necessary information for their use in reviewing home health claims with a date of service between October 1, 2011 and December 31, 2011 that contain diagnosis codes 294.20 and 294.21.

Home Health agencies may want to review any claims with dates of service submitted from October 1, 2011 through December 31, 2011 to make a business decision as to whether or not to adjust the claim based upon a different HIPPS score determination made by V3312 of the HH PPS Grouper.

From the MLN: New Fast Fact and Archive 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® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. You can now view previous fast facts on the [MLN Provider Compliance Fast Fact Archive](#) page. Please bookmark this page and check back often as a new fast fact is added each month.

From the MLN: “Negative Pressure Wound Therapy Interpretive Guidelines” MLN Matters® Article Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1222](#), “Negative Pressure Wound Therapy Interpretive Guidelines” has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.

From the MLN: “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards” Booklet Revised [\[↑\]](#)

[Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Quality Standards Booklet](#) (ICN 905700) has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.

From the MLN: “Quick Reference Information: Preventive Services” and “Quick Reference Information: Medicare Immunization Billing” Revised [\[↑\]](#)

The MLN has revised the recently updated [Quick Reference Information: Preventive Services](#) (ICN 006559) and [Quick Reference Information: Medicare Immunization Billing](#) (ICN 006799) educational tools. We have updated these charts to include the recently released flu code Q2034. All other information remains the same.

From the MLN: “Medicare Fraud & Abuse: Prevention, Detection, and Reporting” Web-Based Training — New [\[↑\]](#)

This Web-Based Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the [MLN Products webpage](#) and click on “Web-Based Training (WBT) Courses” under “Related Links” at the bottom of the webpage.

More Helpful Links...

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