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**National Provider Call: National Physician Payment Transparency Program (OPEN PAYMENTS) - What You Need To Know — Register Now**
*Wednesday, May 22; 2:30-4pm ET*

The National Physician Payment Transparency Program (OPEN PAYMENTS), Section 6002 of the Affordable Care Act, requires manufacturers of pharmaceuticals or medical devices to publically report payments made to physicians and teaching hospitals, creating greater transparency around the financial relationships that occur among them. This National Provider Call will give an overview of what you need to know about OPEN PAYMENTS.

*Agenda:*
- Overview of rule
- Review key program dates
- Your role
- Resources available to you

*Target Audience:* Physicians & Teaching Hospitals. For the purposes of OPEN PAYMENTS, a "physician" is any of the following types of professionals that are legally authorized to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) providers:
- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Dentistry
- Doctor of Dental Surgery
- Doctor of Podiatry
- Doctor of Optometry
- Doctor of Chiropractic Medicine

*Note:* Medical residents are excluded from the definition of physicians for the purpose of this program. More information is available on the OPEN PAYMENTS website.

*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 Notification web page to learn more.

**National Provider Call: Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series — Registration Now Open**
*Thursday May 30; 1:30-3 PM ET*

This session will inform individual practitioners on the basics of Stage 1 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Learn if you are eligible, and if so, what you need to do to earn an incentive. This is the first in a series of 6 National Provider Calls on the Medicare and Medicaid EHR Incentive Programs. Other topics include: Stage 2, clinical quality measures, hardship exceptions, payment adjustments, and a discussion on certification by the Office of the National Coordinator for Health Information Technology.

*Agenda*:

- Are you eligible?
- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and answer session

*Target Audience*: Professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details: Eligibility Requirements for 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.

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**National Provider Call: Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier — Registration Now Open**
*Wednesday, June 5; 1:30-2:30pm ET*

This National Provider Call will cover how to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account in order for (1) physician group practices to select their CY 2013 Physician Quality Reporting System (PQRS) Group Reporting Mechanism, and if applicable, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the Administrative Claims reporting mechanism for CY 2013. A question and answer session will follow the presentation.

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:*

- Introductions and opening remarks
- IACS registration walkthrough
- Question and answer session

*Target Audience:* Physicians, physician group practices, practitioners, therapists, 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 Notification web page to learn more.

**National Provider Calls: Medicare Shared Savings Program Application Process — Registration Now Open**
*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.

Continuing education credit may be awarded for participation in certain CMS National Provider

Calls. Visit the Continuing Education Credit Notification web page to learn more.

**National Provider Call: Audio Recording and Written Transcript from April 23 "Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application" Call Now Available**

The audio recording and written transcript from the April 23 "Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application" call are now available on the April 23 call web page in the "Call Materials" section.

**PERM Cycle 2 Provider Education Webinars**

CMS is hosting four Payment Error Rate Measurement (PERM) provider education webinars for Medicare providers who also provide Medicaid and CHIP services.

*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, May 21 — Webinar
  - Wednesday, June 5 — Webinar
  - Tuesday, June 18 — Webinar
  - Tuesday, July 2 — Webinar

**We All Have a Role to Play in Women's Health**

National Women's Health Week is May 12-18 and National Women's Checkup Day is Monday, May 13. National Women's Health Week is a weeklong health observance coordinated by the HHS Office on Women's Health. It brings together communities, businesses, government, health organizations, and other groups in an effort to promote women's health and its importance. Please join CMS in honoring women during the Month of May by supporting efforts in your community to promote and protect the health, safety, and quality of life of women.

*Did You Know?*
The leading causes of death in females in the United States are:

1. Heart Disease: 24.0%
2. Cancer: 22.2%
3. Stroke: 6.3%
4. Chronic Lower Respiratory Diseases: 5.9%
5. Alzheimer's Disease: 4.5%
6. Unintentional Injuries: 3.5%
7. Diabetes: 2.8%
8. Influenza and pneumonia: 2.3%
9. Kidney Disease: 2.0%
10. Septicemia: 1.6%

*2009 data. Source: Center for Disease Control and Prevention Office of Women's Health website*

*Medicare-Covered Preventive Services of Particular Interest to Women*
Women with Medicare are now covered for many preventive services and screenings that can help them take steps to improve and maintain their physical and mental health and lower their risks of certain diseases, including:

- Alcohol Misuse Screening and Counseling
- Annual Wellness Visit (providing personalized prevention plan services)
- Bone Mass Measurements
- Cancer Screenings such as mammograms, pap tests, pelvic exams (includes a clinical breast exam), and colorectal cancer screenings
- Cardiovascular Disease Screening
- Depression Screening
- Diabetes Screening
- Immunizations (Seasonal Influenza, Pneumococcal, and Hepatitis B)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs
- Tobacco-Use Cessation Counseling

*For More Information:*

- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention website
- CMS Immunizations website
- MLN National Provider Calls and Events website
- DHHS National Women's Health Week and National Women's Checkup Day website

**Proposed Fiscal Year 2014 Payment and Policy Changes for Medicare Skilled Nursing Facilities**

On May 1, CMS issued a proposed rule [CMS-1446-P] outlining proposed FY 2014 Medicare payment rates for skilled nursing facilities (SNFs). Proposals include:

- Changes to payment rates under the SNF Prospective Payment System (PPS)
- Forecast error correction
- Revise and rebase the market basket
- Reporting of distinct therapy days

For more information, see the proposed rule and the Fact Sheet. Public comments on the proposals will be accepted until July 1. More information is available on the SNF PPS website.

**Proposed Fiscal Year 2014 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities**

On May 2, CMS issued a proposed rule outlining proposed FY 2014 Medicare payment policies and rates for the inpatient rehabilitation facilities (IRFs) Prospective Payment System (PPS), as well as updates and changes for the IRF Quality Reporting Program (QRP).

- Proposed changes to IRF payment policies and rates:
    - Updates to the payment rates under the IRF PPS
    - Facility-level adjustment updates
    - "60-percent rule" Presumptive Methodology Code list updates
- Proposed changes to the IRF QRP:

- Prior-year quality measures
- New quality measures
- Proposed changes to the IRF Patient Assessment Instrument
- Proposed reconsideration and disaster waiver processes for quality reporting

For more information, see the proposed rule and the Fact Sheet. Public comments on the proposals will be accepted until July 1.More information is available on the IRF PPS website.

**CMS is Accepting Notices of Intent to Apply for the Medicare Shared Savings Program January 1, 2014 Program Start Date – Due by May 31**

If you are interested in applying for participation for the January 1, 2014 program start date of the Medicare Shared Savings Program, please submit a Notice of Intent to Apply (NOI) *by May 31, 2013*. For more information, visit the Shared Savings Program Application web page. To learn more about the application process, register to attend upcoming National Provider Calls on June 20 and July 18.

**CMS Seeks Public Comment on Defining QIO Service Areas**
*Comments Accepted through Friday, May 31*

On May 2, 2013, CMS issued a request for information (RFI) notice seeking comment about how we can best organize our national cadre of Medicare Quality Improvement Organization (QIO) contractors. We will use the comments from this notice to inform future QIO-related acquisitions.

The notice, numbered "HHS-CMS-CCSQ-RFI-13-QIOProgram: Request for Information to Establish Services Areas for Quality Improvement Organizations (QIOs)," was posted to the FedBizOpps.gov website, a free Internet portal that advertises procurement opportunities, or requests for information about future procurement opportunities across most of the Federal government. The notice is available on the FedBizOpps website. The CMS Quality Improvement Organizations website has additional information.

*About What Is CMS Seeking Comment?*
We seek your comments about four potential options we may use to divide work among a varying number of QIO contractors into service areas (jurisdictions or regions) that are focused on quality-improvement-related work only. We are also seeking fresh new ideas about other options we could consider in organizing QIO contractors. Regardless of how we organize QIOs going forward, we remain committed to keeping grassroots energy and local-level improvement at the heart of what QIOs do.

*Why Is CMS Seeking Comment?*

In 1984, CMS issued its first set of contracts to one organization in all 50 states, DC, and other territories to serve as that state/jurisdiction's QIO contractor. Since then, the field of health care quality improvement has blossomed tremendously. The need for QIOs has evolved from utilization review alone to convening complex local communities that can span state boundaries, particularly as health delivery systems become more horizontally and vertically integrated and new alliances form.

Now that the QIOs' role in health care quality improvement has changed, it is time to think about new and better ways to approach QIO work. Beginning in August 2014, we will launch the next round of QIO Program contracts with a new approach to essential program operations and the service areas for QIOs. In doing so, we hope to maximize program efficiency while improving the quality of care Medicare

beneficiaries receive.

*How Can You Be Heard?*
All comments are welcomed, though comments about how QIOs distribute themselves geographically to best drive large-scale clinical quality improvement are of particular interest. Comments are requested via email by 4pm ET on *Friday, May 31, 2013*. Unfortunately, we cannot answer questions about the RFI, nor can we accept comments in any way other than the email address listed in the RFI text. *Please read the RFI in its entirety, including its Appendix, before commenting.* Get the full text on the FedBizOpps website. Learn more about QIOs on the Quality Improvement Organizations website. Thank you for your commitment to improving the quality, safety, and efficiency of health care for millions of Medicare beneficiaries.

**Transition Plan for the Recovery Audit Program**

CMS has begun the procurement process for the new Medicare FFS Recovery Audit Program contracts. A Request for Quote was issued through the General Services Administration. CMS plans to contract with four A/B Recovery Auditors and one national Durable Medical Equipment (DME) and Home Health/Hospice Recovery Auditor.

CMS has implemented a transition plan to minimize the amount of outstanding work that will transition to the new contracts. The Recovery Audit program will continue during the transition, although there will be some decline in activity.

*Providers should be aware of the following:*

- Additional Documentation Requests (ADRs) will begin to decline in June 2013
- All prepayment reviews will continue without decline
- Post-payment manual therapy reviews will continue without decline

Providers should contact RAC@cms.hhs.gov for questions concerning the transition. Additional information will be posted to the Recovery Audit Program website as it becomes available.

**Less Than One Week to Submit LTCH FY 2014 Data**
*Deadline: Wednesday, May 15*

Long-Term Care Hospital (LTCH) providers should currently be engaging in two activities for the LTCH Quality Reporting (LTCHQR) Program: data *submission* for the FY 2014 payment update determination and data *collection* and *submission* for the FY 2015 payment update determination.

*FY 2014 Payment Update Determination—Deadline for Data Submission: May 15, 2013*

In the FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51743 through 51756, and 51780 through 51781), three measures were adopted for data collection and reporting for October 1 through December 31, 2012 for the FY 2014 Payment Update Determination:

- Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678)
- Urinary Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #0138)
- Central Line Catheter-Associated Bloodstream Infection (CLABSI) (NQF #0139)

To avoid a 2-percentage-point reduction in their Annual Payment Update, providers must submit data for all three measures *by the May 15, 2013 deadline*. Current definitions for the three LTCH quality

measures are available in the LTCHQR Program Manual in the "Downloads" section of the LTCHQR Program website.

The Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678) measure requires use of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set Version 1.01, approved on April 24, 2012, by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (PRA). The OMB Control Number is 0938-1163, Expiration Date April 30, 2013. Please note that while the current PRA approval of the LTCH CARE Data set has an expiration date of April 30, 2013, the subsequent version of the data set is currently in the PRA approval process with the OMB; this acts to extend the PRA deadline of April 30, 2013 until the currently submitted PRA package receives approval. Details on the LTCH CARE Data Set technical submission specifications can be found at LTCHQR Program Technical Information web page.

For the submission of data for CAUTI and CLABSI measures, the deadline for enrollment in Centers for Disease Control and Prevention's (CDC's) National Health Safety Network (NHSN) was December 31, 2012. If you have not registered with the NHSN, please visit the NHSN LTCH web page, and contact the NHSN at NHSN@cdc.gov for additional guidance. Frequently asked questions about the NHSN enrollment process are available on the CDC website.

*Fiscal Year 2015 Payment Update Determination*
In addition to engaging in data *submission* activities for the FY 2014 Payment Update Determination, LTCHs should be engaging in data *collection* and *submission* activities for the FY 2015 Payment Update Determination. Per the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53614 through 53637, and 53667 through 53672), data on three measures will be collected from January 1 through December 31, 2013:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)
- NHSN CAUTI Outcome Measure (NQF #0138)
- NHSN CLABSI Outcome Measure (NQF #0139),

For the four quarters in CY 2013 (i.e., January through March 2013, April through June 2013, July through September 2013, and October through December 2013), the final deadlines for data submission are August 15, 2013, November 15, 2013, February 15, 2014, and May 15, 2014, respectively for FY 2015 Payment Update Determination.

*LTCH CARE Data Set Technical Submission Specification Changes Effective April 21, 2013*
A change has been made to the LTCH data submission specifications scheduled to take effect on April 21, 2013. An errata document for V1.00.3 of the data submission specifications is posted in the "Downloads" section of the under the Downloads section of the LTCHQR Program Technical Information web page.

**CMS is Accepting Suggestions for Potential PQRS and/or Measures Groups**

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. Each measure submitted for consideration must include all required supporting documentation. The Measures Submitted for Consideration Excel Form is posted on the Measures Management System Call for Measures web page. *Only those measures submitted in the provided format will be accepted for consideration*. Questions about this Call for Measures or the required documentation may be submitted to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov.

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. Measure submissions omitting the required core criteria will be disqualified from consideration.

This Call for Measures runs from May 1 through July 1, 2013. *All required documentation* must be completed for each measure submitted for consideration. Completed documentation must be submitted electronically to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov no later than 5pm ET July 1, 2013.

*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.

**CMS ICD-10 Resources**

The CMS website offers resources for providers, payers, and vendors to help prepare for the transition to ICD-10. Resources provide tips and advice on how to plan and execute your transition to ICD-10, including timelines, checklists, and fact sheets:

*ICD-10 Basics*
These resources will introduce you to ICD-10, explain why it's necessary, and give you the information you'll need to get started on your transition.

- FAQs: ICD-10 Transition Basics
- ICD-10 Transition: An Introduction Fact Sheet
- ICD-10 Basics for Medical Practices
- ICD-10 Basics for Payers
- The ICD-10 Transition: Focus on Non-Covered Entities

*Checklists, Timelines, and Implementation Guides*
Checklists and timelines provide an at-a-glance view of what you need to do to get ICD-10 ready. The ICD-10 implementation guides provide detailed information about the ICD-10 transition. Please note that the dates and milestones in these materials are recommendations only; you can adapt them to your needs for meeting the *October 1, 2014*, deadline.

- Checklists with ICD-10 transition tasks and estimated timeframes
    - Small and Medium Practices
    - Small Hospitals
    - Large Practices
    - Payers
- Timelines with suggested dates for important ICD-10 transition activities
    - Small and Medium Practices
    - Small Hospitals

    - Large Practices
    - Payers
- Implementation Guides
    - Small and Medium Practices
    - Small Hospitals
    - Large Practices
    - Payers

*Implementation Planning*
Get step-by-step information to help you plan for the transition.

- Plan to Mitigate Risk for a Smooth Transition
- Planning Your ICD-10 Transition Activities for 2013
- ICD-10 Activities for 2013
- Simple Steps to Improve Clinical Documentation
- Develop Your ICD-10 Communication and Awareness Plan
- The ICD-10 Planning Checklist
- Review How You Use ICD-9 Codes
- Looking Back at Version 5010 and Ahead to ICD-10

*Communicating About ICD-10*
Communication between health care providers, software vendors, clearinghouses, and billing services is an important part of the transition process. Learn how to get the conversation started.

- Talking to Your Customers About ICD-10: Tips for Software Vendors
- Talking to Your Vendors About ICD-10: Tips for Medical Practices
- Communicating with Your Payers About ICD-10
- Communicating with Your Software Vendor

*Medscape Education: CME Credits Available*
Continuing medical education (CME) credits are available to physicians who complete the learning modules for small-medium practices or large practices, but anyone can take them and receive a certificate of completion.

- Medscape Education Modules
- Medscape Expert Article

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

**Interim Process for Hospitals to Bill Part B Services Following Denial of an Inpatient Admission as Not Reasonable and Necessary — Common Billing Scenarios**

On March 13, 2013 CMS issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. The temporary instructions for providers were updated on May 6 with sample claims for the most common billing scenarios.

**Inpatient PPS PC Pricer — Updated**

The FY 2012 Inpatient Prospective Payment System (PPS) PC Pricer has had a printing issue corrected

and is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

**CY 2012 and CY 2013 Home Health PPS PC Pricers — Updated**

The CY 2012 and CY 2013 Home Health (HH) Prospective Payment System (PPS) PC Pricers have had a possible printing issue corrected and are now available on the HH PPS PC Pricer web page in the "Downloads" section.

**"Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article — Revised**

MLN Matters® Special Edition Article #SE1305, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" was revised and is now available in downloadable format. This article is designed to provide education on the implementation of the Phase 2 denial edits and the urgency of ordering/referring providers to submit their Medicare enrollment application. It includes background information, a list of frequently asked questions (FAQS) about the edits and their impact on providers, and additional resources about the Medicare enrollment process. The article was revised to announce a temporary delay in implementing Phase 2 ordering and referring denial edits. Additionally, claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability.

**From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 3]" Educational Tool — Revised**

The "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 3]" Educational Tool (ICN 908625) was revised and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes information on corrective actions that health care professionals can use to address and avoid the top issues of the particular Quarter.

An index of Recovery Audit and Comprehensive Error Rate Testing (CERT) findings from current and previous newsletters is available. This index is customized by provider type to identify those findings that impact specific providers. Visit the Medicare Quarterly Provider Compliance Newsletter Archive page to download the index and view an archive of previous newsletters.

**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) was revised and is now available in downloadable 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**

The "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet (ICN 905711) was revised and is now available in downloadable 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 a 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.