

This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the [archive](#) with other past issues.



**CMS Medicare FFS Provider e-News**  
*CMS Information for the Medicare Fee-For-Service Provider Community*

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

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

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

**The e-News for Thu Feb 16 includes...**

**NATIONAL PROVIDER CALLS**

- Tue Feb 21 – [Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now](#)
- Tue Feb 28 – [Hospital Value-Based Purchasing Program – Register Now](#)
- Wed Feb 29 – [Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Register Now](#)

**OTHER CALLS, MEETINGS, AND EVENTS**

- Thu Feb 23 – [Reminder: Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument](#)
- Thu Feb 23 – [Special Open Door Forum: Prior Authorization of Power Mobility Devices Demonstration](#)

**ANNOUNCEMENTS AND REMINDERS**

- [HHS Announces Intent to Delay ICD-10 Compliance Date](#)
- [New DMEPOS Competitive Bidding Program Analysis Shows No Changes in Health Outcomes](#)
- [Only 2 Weeks Until the Covered Document Review Date for DMEPOS Competitive Bidding Round 2 and National Mail-Order Competition](#)
- [Important Update Regarding HIPAA Version 5010/D.0 Implementation](#)
- [Major Improvements to Medicare Online Enrollment System](#)
- [CMS Seeks Experts for Panel on Measuring Outcomes in Coronary Artery Bypass Graft Procedures – Response Requested by Fri Feb 24](#)
- [Submit Notice of Intent to Apply for Sun July 1 Start Date for Medicare Shared Savings Program – DUE BY FRI FEB 17](#)
- [HHS Releases Reports on Improved Access to Preventive Services Under the Affordable Care Act](#)
- [Healthcare Fraud Prevention and Enforcement Efforts Result In Record-Breaking Recoveries Totaling Nearly \\$4.1 Billion](#)
- [It's Not Too Late to Give and Get the Flu Vaccine](#)

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

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

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

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

*Agenda:*

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

*Registration Information:* In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

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

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

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

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

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

*Agenda:*

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

*Registration Information:* In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

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

**Special National Provider Call Series: Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Register Now** [\[↑\]](#)

*Wed Feb 29; 2:30-4pm ET*

Section 3007 of the *Affordable Care Act* requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the Medicare Physician Fee Schedule starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

This National Provider Call is in support of the efforts of CMS to implement the Medicare Physician Feedback and Physician Value-Based Payment Modifier Programs. This call is one of a series of calls CMS will hold to engage the public in dialogue about physician level value-based purchasing and obtain stakeholder input on how best to implement the physician value modifier.

This National Provider Call will include presentations from a panel of three private sector experts who have had experiences in implementing physician-level pay-for-performance programs. The second call in the series, scheduled for Wed Mar 14, will feature three additional private sector experts.

*Target Audience:* Medicare Fee-for-Service physicians, specialty medical societies, and other interested parties.

*Agenda:*

- Opening Comments and Background – Sheila Roman, MD, MPH; CMS
  - Background on the Value-Based Payment Modifier
  - Introduction of Speakers
- Using Physician Pay-for-Performance to Improve Care – R. Adams Dudley, MD, MBA; University of California, San Francisco
- Quality Measurement: Physician & Practice Performance – Ted von Glahn, MPH; Pacific Business Group on Health
- Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field – Francois de Brantes, MS, MBA; Health Care Incentives Improvement Institute
- CMS Questions and Comment
- General Question and Answer Session
- Closing – Sheila Roman, MD, MPH; CMS

*Registration Information:* In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

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

*Thu Feb 23; 1-2pm ET*

An informational Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is scheduled for Thu Feb 23, 1-2pm. *Topics covered*

during this call will include:

- Data specification updates for October 2012 release
- New process to submit IRF-PAI records to the Assessment Submission Processing (ASAP) System
- Discussion of submitted questions
- Vendor registration on QTSO website
- Email address for IRF Tech Issues mailbox

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

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

*Call-in information:* At the time of the call, dial 866-712-2205 and use conference code 4260581739.

### **Special Open Door Forum: Prior Authorization of Power Mobility Devices Demonstration** [\[↑\]](#)

*Thu Feb 23; 3pm ET*

CMS is pleased to announce that a Special Open Door Forum call on the Prior Authorization of Power Mobility Devices (PMD) demonstration for providers and suppliers will be held on Thu Feb 23 at 3pm. Details about this Special Open Door Forum, including dial-in information, will be posted to <http://go.CMS.gov/PAdemo> soon.

### **HHS Announces Intent to Delay ICD-10 Compliance Date** [\[↑\]](#)

As part of President Obama’s commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G Sebelius today announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10<sup>th</sup> Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013 – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

“ICD-10 codes are important to many positive improvements in our health care system,” said HHS Secretary Kathleen Sebelius. “We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system.”

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* will be required to use the ICD-10 diagnostic and procedure codes.

The full text of this excerpted HHS press release (issued Thu Feb 16) can be found at <http://www.HHS.gov/news/press/2012pres/02/20120216a.html>.

## **New DMEPOS Competitive Bidding Program Analysis Shows No Changes in Health Outcomes** [[↑](#)]

On Sat Jan 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program in nine different areas of the country. Since the program's implementation, CMS has used real-time claims analysis to track groups of Medicare beneficiaries potentially affected by the program. This analysis has consistently shown that the competitive bidding program preserves beneficiary health outcomes.

CMS has now released a broad-view analysis that compares the impact of the program on the general Medicare population as well as Medicare beneficiaries likely to use competitively bid equipment based on their health conditions. For these groups, it compares rates of health outcomes (such as hospitalizations, length of hospital stays, and number of emergency department visits) in the competitive bidding areas to rates in regions without competitive bidding. The new analysis enables an easier comparison between subpopulations and between areas with competitive bidding and without competitive bidding. This results in a clearer depiction of the effect of the DMEPOS competitive bidding program on Medicare beneficiaries' health outcomes. Consistent with prior analyses, we find that beneficiary health outcomes are stable in competitive bidding areas. To view the results, please visit <http://www.CMS.gov/DMEPOSCompetitiveBid>.

- Additional material related to DMEPOS Competitive Bidding in today's e-News... [[next](#)]

## **Only 2 Weeks Until the Covered Document Review Date for DMEPOS Competitive Bidding Round 2 and National Mail-Order Competition** [[↑](#)]

*Reminder:* If you are a supplier bidding in Round 2 and/or the national mail-order competition of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, you must submit your hardcopy financial documents on or before Wed Feb 29, 2012, in order to be eligible to be notified if you have any missing financial documents. *Don't wait – send the required hardcopy documents TODAY!*

The covered document review process gives bidders the opportunity to be notified of missing required financial documents. The Centers for Medicare & Medicaid Services (CMS) urges all bidders to take advantage of this process. Under the covered document review process, we will notify suppliers that submit their hardcopy financial documents by the Covered Document Review Date (CDRD) of any missing financial documents. *The CDRD for the Round 2 and national mail-order competitions is Wed Feb 29, 2012 – financial documents must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Wed Feb 29, 2012, to qualify for the covered document review process.*

The covered document review process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit only the indicated missing financial document(s) within 10 business days of the notification. *Only those suppliers that submit financial documents by the CDRD will receive notice from CMS of any missing financial documents.* Bidders that submit their hardcopy financial documents after the CDRD will not be notified of any missing financial documents. After the bid window closes, bidders may only submit the requested financial documents identified as part of the CDRD process and cannot submit corrections to any other required documents. We encourage bidders to review the [Covered Document Review Date](#) factsheet available on the CBIC website.

Here are some important things to remember when submitting your hardcopy documents:

- Review the Request for Bids (RFB) instructions carefully to be sure that your documents comply with all requirements. The RFB instructions contain

complete instructions for compiling and submitting your documents.

- Put your bidder number on every page of every document. We need your bidder number to match your hardcopy documents with your electronic bid. You will get your bidder number when you complete the Business Organization Information screen in Form A in DBidS, the online bidding system.
- Submit all required hardcopy documents in one package.
- The Round 2 and national mail-order competitive bidding areas (CBAs), product categories, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the [CBIC website](#). Suppliers should review this information prior to submitting their bid(s). CMS will send important information via email during the bidding and contracting periods, so it is very important that you keep the email address registered in IACS current. To update an email address, go to the registration page on the CBIC website.

If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9am and 9pm Eastern Time during the bidding period.

- Additional material related to DMEPOS Competitive Bidding in today's e-News... [\[previous\]](#)

### **Important Update Regarding HIPAA Version 5010/D.0 Implementation** [\[↑\]](#)

CMS has posted to the Versions 5010 & D.0 webpage a new document titled *Important Update Regarding HIPAA Version 5010/D.0 Implementation*, which includes descriptions used for interpreting the 277CA responses, and can be found at [http://www.CMS.gov/versions5010andd0/01\\_overview.asp](http://www.CMS.gov/versions5010andd0/01_overview.asp). This document also includes links to the Common Edits and Enhancement Module (CEM) Error Description documents.

### **Major Improvements to Medicare Online Enrollment System** [\[↑\]](#)

Over the last year, we have listened to your feedback about the Medicare online enrollment system, PECOS (“Provider Enrollment, Chain, and Ownership System”). As a result, we’ve made upgrades in order to reduce data entry time and increase access to information.

Providers and staff using internet-based PECOS will now see the following improvements:

- *Electronic Signature* – You now have the ability to digitally sign and certify the application.
- *Access to More Information* – Now you can see if a request for revalidation has been sent by your MAC.
- *Multiple Views of Your Information* – Switch between Topic View and Fast Track View:
  - The Fast Track View allows you to quickly review all enrollment information on a single screen.
- *Overall Usability* – We are making the system easier to use:
  - You can access previously-used address information when completing an application.
  - You can quickly update and resubmit an application returned for correction via internet-based PECOS as part of any application submission.
  - You will have fewer screens and steps to navigate when you are changing information or revalidating your application(s).

Learn more about PECOS at <https://PECOS.CMS.hhs.gov>, and be on the look-out for more enhancements in the coming months!

### **CMS Seeks Experts for Panel on Measuring Outcomes in Coronary Artery Bypass Graft Procedures – Response Requested by Fri Feb 24** [\[↑\]](#)

CMS has contracted for the development of three individual measures that reflect quality of care for patients undergoing Coronary Artery Bypass Graft (CABG):

- a hospital-level all-cause risk-adjusted readmission measure for CABG developed using clinical registry data [measure developer: Society of Thoracic Surgeons (STS)]
- a hospital-level all-cause risk-adjusted readmission measure for CABG developed using Medicare administrative claims data [measure developer: YNHHS/CORE]
- a hospital-level all-cause risk-adjusted mortality measure for CABG developed using administrative data [measure developer: YNHHS/CORE]

STS and YNHHS/CORE are seeking members for a Technical Expert Panel (TEP) to provide expert opinion and input on this measure. Given the expertise and mission of your organization, STS and YNHHS/CORE would like you to identify individuals who could represent your organization in this process. The goal is to have broad representation on the TEP including experts in CABG surgery, cardiology, and quality improvement / performance measurement, as well as purchaser and consumer perspectives. STS and YNHHS/CORE will hold 5 or 6, 1- to 2-hour teleconference meetings from February to September 2012.

If you or someone you know with relevant expertise would be willing to represent your organization, *please complete the [Nomination/Disclosure/Agreement \(NDA\) form](#) and submit it along with your curriculum vitae and a statement of interest no later than 5pm ET on Fri Feb 24.* (Please note that the due date has been extended from Wed Feb 15 to Fri Feb 24)

*Please note that in order for the nomination package to be complete, a signature (electronic or handwritten) is required on the NDA form.* The documents may be faxed (203-764-5653) or emailed ([CABG@yale.edu](mailto:CABG@yale.edu)). Once the nomination process is complete, STS and YNHHS/CORE will select a TEP composed of 8-15 members based on the areas of expertise and the specific requirements of the measure.

Please contact Lisa Suter (at [CABG@yale.edu](mailto:CABG@yale.edu) or 203-764-5700) should you have any questions.

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

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

### **HHS Releases Reports on Improved Access to Preventive Services Under the *Affordable Care Act* [\[↑\]](#)**

*Affordable Care Act extended free preventive services to 54 million Americans with private health insurance in 2011; free preventive care also provided to 32.5 million in Medicare.*

HHS Secretary Kathleen Sebelius announced on Wed Feb 15 that the *Affordable Care Act* provided approximately 54 million Americans with at least one new free preventive service in 2011 through their private health insurance plans, and that an estimated 32.5 million people with Medicare received at least one free preventive benefit, including the new Annual Wellness Visit. Together, this means an estimated 86 million Americans were helped by health reform's prevention coverage improvements. The new data were released in two new reports from HHS.

The *Affordable Care Act* requires many insurance plans to provide coverage without cost-sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults. The law also makes proven preventive services free for most people on Medicare.

The report on private health insurance coverage also examined the expansion of free preventive services in minority populations. The results showed that an estimated 6.1 million Latinos, 5.5 million Blacks, 2.7 million Asian Americans, and 300,000 Native Americans with private insurance received expanded preventive benefits coverage in 2011 as a result of the new healthcare law.

The report discussing Medicare preventive services found that more than 25.7 million Americans in traditional Medicare received free preventive services in 2011. The report also looked at Medicare Advantage plans and found that 9.3 million Americans – 97 percent of those in individual Medicare Advantage plans – were enrolled in a plan that offered free preventive services. Assuming that people in Medicare Advantage plans utilized preventive services at the same rate as those with traditional Medicare, an estimated 32.5 million people benefited from Medicare’s coverage of prevention with no cost-sharing.

The full report on expanded preventive benefits in private health insurance is available at <http://aspe.HHS.gov/health/reports/2012/PreventiveServices/ib.shtml>. The report on expanded preventive benefits in Medicare and other ways that the *Affordable Care Act* strengthens Medicare is available at <http://www.CMS.gov/newsroom>.

The full text of this excerpted HHS press release (issued Wed Feb 15) can be found at <http://www.HHS.gov/news/press/2012pres/02/20120215a.html>.

➤ Additional material related to Preventive Health Services in today’s e-News... [\[next\]](#)

### **Healthcare Fraud Prevention and Enforcement Efforts Result In Record-Breaking Recoveries Totaling Nearly \$4.1 Billion [\[↑\]](#)**

On Tue Feb 14, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius released a new report showing that the government’s healthcare fraud prevention and enforcement efforts recovered nearly \$4.1 billion in taxpayer dollars in FY2011. This is the highest annual amount ever recovered from individuals and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

These findings, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste, and abuse in the Medicare and Medicaid programs, and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the *Affordable Care Act*.

The recently-enacted *Affordable Care Act* provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional \$350 million for HCFAC activities. The administration is already using tools authorized by the *Affordable Care Act*, including enhanced screenings and enrollment requirements, increased data-sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

The departments also continued their successes in civil healthcare fraud enforcement during FY2011. Approximately \$2.4 billion was recovered through civil healthcare fraud cases brought under the *False Claims Act (FCA)*. These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. This marked the second year in a row that more than \$2 billion has been recovered in *FCA* healthcare matters and, since January 2009, the department has used the *FCA* to recover more than \$6.6 billion in federal healthcare dollars.

The fraud prevention and enforcement report announced on Tue Feb 14 coincided with the announcement of a proposed rule from CMS aimed at recollecting overpayments in the Medicare program. Before the *Affordable Care Act*, providers and suppliers did not face an explicit deadline for returning taxpayers’ money.

Thanks to the *Affordable Care Act*, there will be a specific timeframe by which self-identified overpayments must be reported and returned.

The HCFA annual report can be found at <http://oig.HHS.gov/publications/hcfac.asp>. More information on the fraud prevention accomplishments under the *Affordable Care Act* can be found at <http://www.Healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html>.

*The full text of this excerpted HHS press release (issued Tue Feb 14) can be found at <http://www.HHS.gov/news/press/2012pres/02/20120214a.html>.*

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

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

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

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

➤ Additional material related to Preventive Health Services in today's e-News... [[previous](#)]

#### **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)