

Informedika's Steve Yaskin Designs a Solution for His Wife, the Doctor

☒ I get pitched new products and services every day and it is pretty rare that I hear of something that is startlingly new. Informedika is just that – it addresses an old, old problem for practices in a new way. Continue reading for a very interesting interview with Informedika Founder and CEO Steve Yaskin.

Mary Pat: *Tell us how Informedika came to be.*

Steve: I am the founder and CEO of several high-tech companies in Silicon Valley and I've spent many years passionately solving problems using technology. In 2011 my attention turned to a problem that my wife, Dr. Inna Yaskin, faced in her medical practice every single day – the astoundingly inefficient process of ordering diagnostic tests and dealing with the results.

Electronic prescribing (E-Prescribing) was already becoming widely accepted due to the greater efficiency and accuracy of an electronic prescription compared with a hand-written one. But lab and radiology requisitions were still being handled using the phone and fax machine – a time-consuming, error-prone, and frequently unreliable medium. As a result, Dr. Yaskin and her staff were wasting a huge amount of time addressing errors and confusion – time that could be spent on patient care. So, I thought, if we can have E-Prescribing, why not E-Requisitions?

I set out to bring diagnostics into the 21st century, and founded Informedika, Inc. As well as building an innovative cloud-based solution for orders and results, partnerships with diagnostic service providers would be critical. Laboratories,

radiology centers and genetic testing facilities were quick to see the benefits of E-Requisitions in addressing inefficiencies at their end too.

We soon realized that Informedika wasn't just about features – it was about connecting healthcare providers to service providers and to each other in order to make healthcare delivery more effective, and ultimately improve quality of care. So Informedika became the Informedika E-Requisition Network.

Mary Pat: What exactly is an E-Requisition Network?

Steve: The Informedika Portal provides true bi-directionality for both requisitioning and processing diagnostic results, DME supplier ordering and mHealth device provisioning. This means we can offer labs (phlebotomy, pathology, genetics, and imagery) as well as Rx, wheel chairs and other DME, mHealth devices, and most kinds of information not typically available in EMR products today in “one pane of glass.” We deliver this free to physicians and other authorized clinicians.

Mary Pat: Your site talks about “seamless EMR integration.” Which EMRs does Informedika integrate with and how is it integrated?

Steve: For those EMR solutions that provide open APIs (application program interface), Informedika easily allows bi-directional data movement. Informedika has additional options to move information to EMRs that accept data in the following ways:

- Continuation of Care Document (CCD)
- “Drag & Drop” hotlinking
- PDF creation
- Secure Messaging Interface

Mary Pat: *I see that radiology images can be viewed via your software – is that in beta or is that actually in use at a practice?*

Steve: It is in use. In addition to radiology reports, the imagery is available in the Informedika Portal – this includes CT scans, MRI, Ultrasound, and, of course, X-rays. We use industry-standard DICOM to process imaging in our portal. No software is required to access the radiology imaging in Informedika portal.

Mary Pat: *One of the problems physicians face is the duplication of records and results flowing into the practice. Does your system help to eliminate duplication of reports?*

Steve: Yes, the Informedika Portal helps eliminate duplication of reports by using a central patient charting system. Our patent-protected patient-matching algorithm facilitates collecting data and providing access to the authorized users. Informedika detects possible duplicate orders as well, while presenting previously done results and studies.

Mary Pat: *This is one of the most exciting concepts I've heard of recently – how long has Informedika been on the market?*

Steve: Informedika soft-launched in the summer of 2012. We plan to make a little more noise this summer.

Mary Pat: *What is the cost to physicians to use Informedika?*

Steve: The Informedika Portal is offered free to clinicians: MDs, DOs, NPs, PAs, and soon pharmacists. We also provide access to staff at SNFs (skilled nursing homes), Assisted Living facilities and Home Health agencies to facilitate care coordination, electronic ordering and digital signing of the documents.

Mary Pat: *Do you have any case studies on the savings that physicians can realize by using Informedika?*

Steve: We are collecting these metrics now – we had conducted several studies with an initial group of primary care doctors and calculated monthly savings to be \$4,000 per doctor per month. We also produce additional billing claims for participating practices for the Care Coordination. We calculated unbilled claims results as \$100 per patient after they had been discharged from the hospital. Informedika produces additional revenue for physicians for the work they already perform while incentivizing them to take a more active part to prevent hospital re-admissions.

Mary Pat: *Your product seems ideal for ACOs – do you have any ACOs using Informedika?*

Steve: We are working actively with Accountable Care Organizations (ACOs) across the country. In addition to processing requisitions and delivering results, each ACO requires specific workflows regarding high-risk patients and, of course, re-admission decision support. The Informedika Portal allows for these functions to be customized for each ACO. Additionally, Informedika e-requisitions use live compendiums, authenticate the user, and check for eligibility – these are all required under the new ACO rules. Most importantly, we offer Business Intelligence to ACOs allowing them to negotiate better contracts, distribute payments to participating physicians and close the leakage problems when physicians order diagnostics from non-preferred and potentially more expensive providers.

Mary Pat: **Informedika sounds like the answer to a prayer for physicians, but I have to ask: why hasn't anyone else been able to accomplish this before now?**

Steve: We hear this question quite a bit and the answer is not complex. When we looked at the problem of diagnostic testing and results with fresh eyes and a Silicon Valley viewpoint – with no agenda other than providing information to physicians in the best way possible – we came up with a platform that is

agnostic to legacy systems – in other words: we started with a blank piece of paper and built the system that pretty much anyone might specify if they were not already busy defending legacy applications.



You can watch their video here: [“Informedika in 120 seconds”](#)

For more information, contact Steven Sattler at [\(415\) 722-7586](#) or visit the Informedika website at www.informedika.com.

A Guide to Healthcare Buzzwords and What They Mean: Part One (A through L)

Welcome to our guide to Healthcare Buzzwords!



ACO

An acronym for “Accountable Care Organization”, an ACO is a model of healthcare delivery in which a group of healthcare providers agree to accept payment for their services based on

the aggregated health outcomes of the patients they see, as opposed to the total number of services performed. ACOs reward providers in a “fee for health” model, as opposed to a traditional “fee for service” model. Although the term ACO can apply to a variety of types of organizations, regulations for establishing ACOs to participate in the Medicare Shared Savings Program specifically were included in the Patient Protection and Affordable Care Act of 2010.

Big Data

“Big Data” is a blanket term used to describe the tremendous amount of raw data that we create as part of our everyday lives. As we become more proficient in capturing, storing, and analyzing these massive data sets – and the increasingly complex tools needed to do so – there is tremendous hope in the ability for industries to glean insights from the mountain of data they already have. Healthcare, with the tremendous amount of data that is already collected and stored in the form of medical records, is considered one of the areas with the most to gain from advances in “Big Data” tools.

CCHIT

An acronym for “Certification Commission for Healthcare Information Technology”, CCHIT is one organization authorized by the Office of the National Coordinator of the Department of Health and Human Services to certify Electronic Health Record products for quality, security and interoperability. This certification is necessary for providers to receive “stimulus” funds from Medicare or Medicaid as reimbursement for achieving “Meaningful Use” of the EHR. Other organizations providing certifications include Drummond Group, ICSA Laboratories, Inc. and InfoGuard Laboratories, Inc.

Cloud vs. Closet

The “Cloud” versus the “Closet” is a way of defining the two most common ways of managing and sharing software products in a medical practice. The “Closet” is the traditional model where a server is installed, often into an extra closet where the phone system is also kept that runs the Practice Management and/or Electronic Medical Record software on the desktops in the practice. Generally, the practice owns their own software and hardware, and pays for it upfront as a capital expense. In the “Cloud” model, which is rapidly gaining favor, a constant Internet connection allows the server hardware to be kept offsite in the vendor’s data center. The software is paid for on a monthly, operational expense basis, and security, upgrades and maintenance are all outsourced to the vendor.

EMR/EHR

Acronyms for “Electronic Medical Record” and “Electronic Health Record.” The two terms are generally used interchangeably to describe any software that documents medical services delivered between providers and patients. There is however a general distinction between the two, highlighted [in this blog post from the ONC](#). An Electronic Medical Record generally refers to the digitized version of a paper record that is kept in an office as a record of the patient’s services from that provider. In other words, only the patient’s interactions with the providers of that office. An Electronic Health Record on the other hand generally refers to the complete history of a patient’s life and conditions as they visit different providers in different health settings. With the EHR’s focus on health as opposed to medicine, and portability with the patient as opposed to static and office-based, EHR tends to be the “official” term used by the ONC.

eRx

“eRx” is an abbreviation for “e-prescribe”, or the ability to transmit information from a provider to a pharmacy and back to facilitate filling prescriptions with a completely electronic process. By eliminating the paper scripts and the patients having to take them to their pharmacy, eRx facilitates more accurate, timely information between prescriber and pharmacy, and ensures that the information is accurately logged into the patient’s EHR. The ability to e-prescribe is a component of achieving Meaningful Use for providers to receive stimulus funds.

HDHP

An acronym for “High Deductible Health Plan”, an HDHP is a type of insurance coverage where more of the initial cost of care is shifted to the responsibility of the patient. Using higher deductibles, as well as co-pays or co-insurance, high-deductible health plans are often combined with Health Savings Accounts to provide health coverage at lower premiums for patients and/or employers. As health insurance costs continue to rise, HDHPs are becoming more popular as a coverage model.

HIE #1 (Health Information Exchange)

A Health Information Exchange is a central hub where different health providers and locations can “exchange” electronic medical information so that a patient’s medical history is available to any provider or care setting in which the patient receives treatment. The exchange allows for the health data to be shared across different types of software in different places, so access to the exchange insures access to the most accurate patient data available. Health Information Exchanges are being set up in regional, state and national settings, and

were a key part of Patient Protection and Affordable Care Act (PPACA or ACA) of 2010.

HIE #2 (Health Insurance Exchange)

A Health Insurance Exchange is a controlled marketplace where consumers can compare and purchase health insurance, as well as find out about any subsidies or tax benefits they can take advantage of to offset the cost of coverage. Each state has the option of setting up their own state-level exchange, or participating in the federally-run exchange. The exchange also sets minimum coverage levels for each state, and mandates that insurance companies disclose actuarial percentages and coverage levels of similar plans so that consumers can make informed decisions about coverage.

HIM

Health Information Management is the field of study that deals with overseeing and maintaining health care information for a patient population. Although HIM refers to the management of both paper-based and electronic health records, the field increasingly focuses on the storing, securing, and disclosing of electronic data. Issues like ethics, health informatics, and health information policy are changing the way Health Information Management is viewed in the larger context of the healthcare system.

HIPAA

An acronym for the “Health Insurance Portability and Accountability Act of 1996”, HIPAA is a federal statute that was designed to regulate health insurance to make it easier to “carry” coverage with you after leaving a job, as well as to set standards for the protection and transmission of protected health information. HIPAA was appended by the HITECH Act of

2009 to set disclosure reporting requirements in the case of a breach as well as define business associates as entities covered under HIPAA. Generally, when people refer to “HIPAA Requirements” they are talking about the privacy restrictions of the two bills.

HSA

An acronym for “Health Savings Account”, an HSA is a specialized bank account that allows its holder to defer federal tax liability in order to save for future medical expenses. Money deposited in an HSA is not subject to Federal Income Tax. HSAs, like a flexible spending account, or a health reimbursement account are combined with a high deductible health plan to replace traditional health insurance with money from the HSA covering short term costs and helping with patient responsibilities while the HDHP covers catastrophic injuries or illness.

ICD-10

ICD-10 is an abbreviation for “International Statistical Classification of Diseases and Health Related Problems, 10th revision”. The ICD system is the set of alphanumeric codes that are used to classify diseases and bill medical payers for services. The United States currently uses the ICD-9 system, but is set to switch to the new standard on October 14, 2014. ICD-10 is much more complex than ICD-9, with almost five times as many available codes, and a much more specific hierarchy. ICD-10 is also referred to as “**I-10.**”

Interoperability

Interoperability is the concept that information stored in EHR software should be usable by any other software package. Interoperability is key to coordinating and improving care,

because the health information is worthless without the software compatibility to share it between providers. This “breaking down of barriers” between different EHR software packages is crucial not only to sharing health information, but to creating a thriving and innovative healthcare information technology marketplace. Examples are a hospital system EMR’s interoperability with a private practice EMR, and both system’s EMR interoperability with a reference laboratory’s Information System.

IPA

An acronym for “Independent Practice Association”, an IPA is a group of independent physicians, or groups representing independent physicians to contract their services to managed care organizations and payers. IPAs can be formed to collaborate on care in a region, promote the political effectiveness of the independent physician, as well as to negotiate professional fees for their members, although it is important to note that the IPA does not negotiate on behalf of its members for services delivered outside managed care agreements because of federal trade laws.

What are some of the buzzwords you are hearing, wondering about, and maybe even growing tired of? Let us know in the comments!

Medicare News for Week of April 17, 2012: CMS Website

Upgraded, 2 National Provider Calls, Proposed CQMs for MU Stage 2 and 27 ACOs are Announced

(Website) CMS.gov Website Upgrade Completed-Check your Bookmarks [\(jump to story\)](#)

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(PQRS & eRx) National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now [\(jump to story\)](#)

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

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(MU) CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website [\(jump to story\)](#)

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(EFT) All Medicare Provider and Supplier Payments to be Made by Electronic Funds Transfer [\(jump to story\)](#)

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(ACOs) New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start [\(jump to story\)](#)

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(5010) A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources [\(jump to story\)](#)

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(MLN) Medicare Learning Matters Updates [\(jump to story\)](#)

CMS.gov Website Upgrade Completed-Check

your Bookmarks

CMS has completed the upgrades to the www.CMS.gov website. Bookmarked links to items posted in the “Downloads” sections on the CMS website have not been affected, but other bookmarked URLs are redirected to the index webpage for that topic. For example, if you bookmarked the page containing National Provider Calls and Events, you will be taken to the index page for National Provider Calls. On the index page, select the webpage you’d like to view from the left-hand side. Once you open the correct page, you can create a new bookmark. We appreciate your understanding and apologize for any inconvenience during this process.

Home Health:

<http://www.cms.gov/Center/Provider-Type/Home-Health--Agency-HHA-Center.html>

Hospice:

<http://www.cms.gov/Center/Provider-Type/Hospice-Center.html>
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National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now

Tuesday, April 17, 2012; 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 Electronic Prescribing 10-Month Feedback Report.

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 Electronic Prescribing 10-Month Feedback Report
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. 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 at <http://www.CMS.gov/Medicare/-Quality-Initiatives-Patient-Assessment-Instruments/PQRS/-CMSponsoredCalls.html>. In addition, the presentation will be emailed to all registrants on the day of the call.

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National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now

Wednesday April 25, 2012; 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 focuses on addressing the current 5010/D.0 metrics, addressing recommendations made by Medicare FFS, as well 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 at <http://www.eventsvc.com/blhtechnologies>. 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 and Webinar: The presentation for this call will be posted at least one day in advance at <http://www.CMS.gov/Outreach-and-Education/Outreach/NPC/-National-Provider-Calls-and-Events-Items/042512-NPC-Call.-html>. In addition, the presentation will be emailed to all registrants on the day of the call. CMS will be using an optional webinar feature as part of this National Provider Call. Complete details on this feature are available on the call registration page.

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CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website

CMS has posted the full set of [proposed Clinical Quality Measures \(CQMs\) for 2014](#) as part of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Stage 2

Notice of Proposed Rule Making (NPRM). The public can review the CQMs and submit feedback online.

Proposed CQMs

The proposed CQMs are outlined in two tables that describe each measure and provide additional information for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) beyond the descriptions listed on the National Quality Forum (NQF) website. Some of these measures are still in development; therefore, the descriptions provided in these tables may change before the final rule is published. When possible, links have been provided for measures that have corresponding information on the NQF website. If a measure does not have an NQF number, it means that measure has not yet been endorsed.

Public Comment

Public comments regarding these measures should be submitted using the same method required for all comments related to the proposed rule. You can submit public comments online through the [federal regulations website](#). The deadline for public comments relating to the proposed CQMs and other aspects of the Stage 2 NPRM is *Mon May 7, 2012*.

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website at <http://www.cms.gov/EHRIncentivePrograms> for the latest news and updates on the EHR Incentive Programs.

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All Medicare Provider and Supplier

Payments to be Made by Electronic Funds Transfer

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.* For more information about provider enrollment revalidation, review the [MLN Matters® Special Edition Article #SE1126](#), "Further Details on the Revalidation of Provider Enrollment Information."

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New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start

Over 1.1 Million Beneficiaries Now Served by Accountable Care Organizations

A new program that will help physicians, hospitals, and other health care providers work together to improve care for people with Medicare is off to a strong start.

Under the new Medicare Shared Savings Program (Shared Savings

Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to Accountable Care Organizations are made possible by the *Affordable Care Act*, the health care law of 2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider they wish.

The first 27 Shared Savings Program ACOs will serve an estimated 375,000 beneficiaries in 18 States. This brings the total number of organizations participating in Medicare shared savings initiatives on Sun Apr 1 to 65, including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January, 2011. In all, as of Sun Apr 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

CMS also announced today that five ACOs are participating in the Advance Payment ACO Model beginning Sun Apr 1. This model will provide advance payment of expected shared savings to rural and physician-based ACOs participating in the Shared Savings Program that would benefit from additional start-up resources. These resources will help build the necessary care coordination infrastructure necessary to improve patient outcomes and reduce costs, such as new staff or information technology systems. CMS is reviewing more than 50 applications for Advance Payments that start in July. For more information on the Advanced Payment ACO Model, including the participating ACOs, visit <http://innovations.CMS.gov/-initiatives/ACO/Advance-Payment/>.

The full text of this excerpted CMS press release (issued Tue

Apr 10) can be found at <http://www.CMS.gov/apps/media/-press/release.asp?Counter=4333>, and a media fact sheet can be found at <http://www.CMS.gov/apps/media/-press/factsheet.asp?Counter=4334>.

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A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources

CMS will not initiate enforcement action against *HIPAA*-covered entities for an additional three months, through Sat June 30, 2012, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help *HIPAA*-covered entities with the upgrade, CMS continues to update and improve their Version 5010 resources.

Updated FAQ System

CMS has updated the FAQ system and the way it is organized. There are now three ways to more easily find Version 5010 FAQs by going to the [CMS FAQs Page](#) and:

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
 - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page

- Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term “Version 5010” in the *Search* box on the upper left side of the page

CMS’ Version 5010 and D.0 FAQs can also be found on the [Version 5010 page](#) of the ICD-10 website, on the [FAQs: Versions 5010 and D.0 Transition Basics fact sheet](#). The newest FAQ recently added by CMS is:

Question: Is my Version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

Answer: Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 Report has situational usage and language that says “If not required by this implementation guide, do not send.”
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 Report.

Version 5010 Testing Readiness Fact Sheet

CMS also has a [Version 5010 Testing Readiness Fact Sheet](#), which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can

help providers to determine steps to successfully complete testing phases for Version 5010.

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, and to download and share the implementation [widget](#) today!

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Medicare Learning Matters Updates

Information on the CMS Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives – [MLN Matters® Special Edition Article #SE1211](#), “Information on the Centers for Medicare & Medicaid Services (CMS) Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives” has been released and is now available in downloadable format.

This article is designed to provide education on the CMS National Fraud Prevention Program (NFPP) and processes used to prevent Medicare fraud and abuse. It includes information about two new initiatives that CMS uses as part of the provider enrollment process – automated provider screenings and national site visit contractors that conduct site visits for certain providers and suppliers.

Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012 – [MLN Matters® Special Edition Article #SE1215](#), “Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012” has been released and is now available in downloadable format.

This article includes an overview of the provisions that impact Medicare Fee-For-Service providers, including Section 3003, which extends the current zero percent update for claims with dates of service on or after Thu Mar 1, 2012 through Mon Dec 31, 2012.

Redesigned Medicare Summary Notices – [MLN Matters® Special Edition Article #SE1218](#), “Redesigned Medicare Summary Notices” has been released and is now available in downloadable format.

This article is designed to provide education on the redesigned Medicare Summary Notice (MSN), which is part of the “Your Medicare Information: Clearer, Simpler, At Your Fingerprints” initiative. It includes information about key features and enhancements to the redesigned MSN and steps CMS will take to make benefits, provider, and claims information clearer and more accessible.

Avoiding Medicare Fraud & Abuse: A Roadmap for Physician, Web-Based Training Now Available – This web-based training is designed to provide education on fraud and abuse related to physicians. It includes definitions, laws exclusions, civil monetary penalties, case examples, and resources.

To access a new or revised web-based training course, visit <http://www.CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> and click on “Web-Based Training (WBT) Courses” under “Related Links” at the bottom of the webpage.

Submit Feedback on MLN Products and Services –

The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the [MLN Opinion Page](#) to submit an anonymous evaluation about specific MLN products and resources. Your feedback is important in developing and improving future MLN products and services.

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