

Thursday, September 25, 2014

## **MLN Connects™ National Provider Calls**

Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings — Registration Opening Soon  
Hospital Appeals Settlement Update — Registration Now Open  
Transitioning to ICD-10 — Register Now  
New MLN Connects™ National Provider Call Video Slideshow

## **Announcements**

Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3  
National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal  
Hospital Appeals Settlement: New FAQs Posted  
Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30  
2014 PQRS 2<sup>nd</sup> Quarter Interim Feedback Dashboard Reports Available  
2013 PQRS and eRx Incentive Program Incentive Payments Available  
2013 PQRS and eRx Incentive Program Feedback Reports Available  
2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available  
Completion and Submission Timeframes for Hospice Item Set Records  
Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape  
New Resources and Webinars from National Health IT Week  
PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting  
2014 CAHPS for PQRS Survey  
New PQRS FAQs Available  
New and Updated FAQs for the EHR Incentive Programs

## **Claims, Pricers, and Codes**

FDG PET for Solid Tumor Claims

## **Medicare Learning Network® Educational Products**

“Medicare Billing Information for Rural Providers and Suppliers” Booklet — Revised  
“Rural Health Clinic” Fact Sheet — Revised  
“Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians” Fact Sheet — Revised  
“Critical Access Hospital” Fact Sheet — Revised  
Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

## **MLN Connects™ National Provider Calls**

## Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings — Registration Opening Soon

Wednesday, October 8; 1:30-3pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Registration will be opening soon.

CMS plans to begin publicly reporting Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Star Ratings on the [Hospital Compare](#) website in April 2015. During this MLN Connects™ National Provider Call, CMS will discuss the implementation of the HCAHPS Star Ratings. Participants will gain an understanding of the HCAHPS Star Ratings and how they are calculated. Hospitals interested in seeing how their facility is represented will want to participate in the call to hear details about the new HCAHP Star Ratings.

CMS is adopting star ratings across Medicare.gov Compare websites to help consumers more easily understand the information on the websites and make more informed decisions when comparing and choosing healthcare providers.

### Agenda:

- Introduction
- Rationale for adding star ratings to the Compare websites
- Description of HCAHPS Star Ratings and methodology
- Hospital Compare Preview Report details
- Resources
- Q&A session

*Target Audience:* All Fee-For-Service providers and hospital associations, hospitals participating in the HCAHPS Survey, and HCAHPS survey vendors

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

## Hospital Appeals Settlement Update — Registration Now Open

Thursday, October 9; 1:30-3pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

This MLN Connects™ National Provider Call will provide updates about the administrative agreement for acute care hospitals and critical access hospitals (CAHs) to expediently resolve appeals of patient status denials. This is a follow-up to the [September 9 call](#), and will provide another opportunity for live Q&A before administrative agreement requests are due to CMS on October 31, 2014. For details about the providers and claims eligible for administrative agreement, as well as updated documents needed to request an agreement, visit the [Inpatient Hospital Reviews](#) web page. *Note: You do not need to wait until after this call to submit your settlement request.*

CMS encourages interested parties to submit questions in advance of the call. Submitted questions may be addressed on the call or may be used to create frequently asked questions (FAQs) that will be posted to the CMS website.

### Agenda:

- Update on the hospital appeals settlement
- Latest FAQs
- Open Q&A

*Target Audience:* Acute care hospitals, including those paid via the prospective payment system, periodic interim payments, and the Maryland waiver; and CAHs. A full definition of each of these facility types can be found at §1886(d) or §1820(c) of the Social Security Act.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **Transitioning to ICD-10 — Register Now**

*Wednesday, November 5; 1:30-3pm ET*

*To Register:* Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

HHS has issued a [rule](#) finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss ICD-10 implementation issues, opportunities for testing, and resources. A question and answer session will follow the presentations.

#### *Agenda:*

- Final rule and national implementation
- Medicare Fee-For-Service testing
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project
- Partial code freeze and annual code updates
- Plans for National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Home health conversions
- Claims that span the implementation date

*Target Audience:* Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **New MLN Connects™ National Provider Call Video Slideshow**

A video slideshow is now available for the following call:

- [September 9](#) — CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Patient Status Denials, [video slideshow](#)

Call materials for MLN Connects™ Calls are located on the [Calls and Events](#) web page.

## **Announcements**

### **Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3**

During the week of January 26 through 30, 2015, a sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The goal of end-to-end testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-For Service (FFS) claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate Remittance Advices are produced

Approximately 850 volunteer submitters will be selected to participate in the January end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers.

*To volunteer as a testing submitter:*

- Volunteer forms are available on your [MAC](#) website
- Completed volunteer forms are due October 3
- CMS will review applications and select the group of testing submitters
- By October 24, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

Additional opportunities for end-to-end testing will be available in 2015. Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

*For more information:* [MLN Matters® Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach.”

### **National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal**

*Coalition provides tools and support to achieve continued decreases*

On September 19, The National Partnership to Improve Dementia Care, a public-private coalition, established a new national goal of reducing the use of antipsychotic medications in long-stay nursing home residents by 25 percent by the end of 2015, and 30 percent by the end of 2016. The coalition includes CMS, consumers, advocacy organizations, providers, and professional associations.

Between the end of 2011 and the end of 2013, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 15.1 percent, decreasing from 23.8 percent to 20.2 percent nationwide. The National Partnership is now working with nursing homes to reduce that rate even further.

While the initial focus is on reducing the use of antipsychotic medications, the Partnership’s larger mission is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices. CMS will monitor the reduction of antipsychotics as well as the possible consequences.

Some states have achieved significant reduction in their rate of antipsychotic usage. For example, Georgia reduced its rate by 26.4 percent and North Carolina saw a 27.1 percent reduction.

The Partnership has engaged the nursing home industry across the country around reducing use of antipsychotic medications with momentum and success in this area that is expected to continue. In 2011, Medicare Part D spending on antipsychotic drugs totaled \$7.6 billion, which was the second highest class of drugs, accounting for 8.4 percent of Part D spending.

In addition to posting a measure of each nursing home’s use of antipsychotic medications on the CMS Nursing Home Compare website, in the coming months CMS plans to add the antipsychotic measure to the calculations that CMS makes for each nursing home’s rating on the agency’s Five Star Quality Rating System.

Fact sheet: Data show National Partnership to Improve Dementia Care exceeds goals to reduce unnecessary antipsychotic medications in nursing homes.

Full text of this excerpted [CMS press release](#) (issued September 19).

### **Hospital Appeals Settlement: New FAQs Posted**

Updated FAQs were posted to the [Inpatient Hospital Reviews](#) web page on September 22. They can be found in the “Downloads” at the bottom of the page. Don’t forget to [register](#) for the MLN Connects™ National Provider Call on October 9. Also, a [video slideshow](#) linking the audio and slides from the MLN Connects™ Call on September 9 is now available. Email any questions to [MedicareSettlementFAQs@cms.hhs.gov](mailto:MedicareSettlementFAQs@cms.hhs.gov).

### **Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30**

Eligible professionals (EPs) who wish to participate in the 2014 Physician Quality Reporting System (PQRS) program as a group practice can now register for the [group practice reporting option \(GPRO\)](#). When your group is ready to register, you can access the Physician Value-PQRS (PV-PQRS) Registration System at <https://portal.cms.gov>. You will need to use a valid Individuals Authorized Access to the CMS Computer Services (IACS) User ID and password to choose your group’s reporting mechanism. The registration system will be open *until September 30* for the 2014 PQRS program. Additional information about the 2014 GPRO registration and how to register is available on the [Self Nomination/Registration](#) web page.

#### *Participating as a Group Practice*

Group practices participating in the GPRO that satisfactorily report data on PQRS measures during the 2014 reporting period (January 1 through December 31) are eligible to earn the 0.5% incentive payment and will avoid the -2% 2016 PQRS payment adjustment. To earn an incentive for the 2014 PQRS program year and avoid the 2016 PQRS payment adjustment, group practices with 2 or more EPs may register to participate in GPRO via:

- Qualified PQRS registry
- Directly from Electronic Health Record (EHR) using certified EHR technology (CEHRT)
- CEHRT via data submission vendor

If your group has 25 or more EPs, you can also participate in GPRO via:

- Web interface (reporting Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS also required for groups of 100+)
- CAHPS for PQRS via CMS-certified survey vendor (supplement to other PQRS reporting mechanisms)

#### *Value Modifier*

In CY 2016, the Value Modifier will apply to groups of physicians with 10 or more eligible professionals and will be based, in part, on their reporting and performance on quality measures in CY 2014. These groups have two ways to participate in the PQRS in CY 2014 in order to avoid the -2.0 percent Value Modifier payment adjustment in CY 2016: group reporting or individual reporting.

- Groups that want to report under the PQRS as a group must register to participate in the PQRS GPRO by September 30, 2014 and report successfully to avoid the CY 2016 PQRS payment adjustment and to avoid the -2.0 percent Value Modifier payment adjustment.
- Alternatively, groups that want their EPs to report individually under the PQRS must have at least 50 percent of their EPs report successfully to avoid the -2.0 percent Value Modifier payment adjustment.

Groups between 10 and 99 EPs that satisfactorily report PQRS could qualify for an upward or neutral payment adjustment in 2016 under the Value Modifier based on their performance on quality and cost measures in 2014.

For groups of 100 or more EPs that satisfactorily report PQRS in 2014, the Value Modifier could provide an upward, neutral or downward payment adjustment based on their performance on quality and cost measures in 2016. For more information, please visit the [Value Modifier](#) web page.

#### *Additional Resources*

For more information about how to participate in the 2014 PQRS program through the GPRO, review the [2014 PQRS GPRO Requirements](#) document. For questions about how to register, contact the QualityNet Help Desk at 866-288-8912 (TTY: 877-715-6222) or at [Qnetsupport@hcqis.org](mailto:Qnetsupport@hcqis.org).

### **2014 PQRS 2<sup>nd</sup> Quarter Interim Feedback Dashboard Reports Available**

The 2014 Physician Quality Reporting System (PQRS) 2<sup>nd</sup> Quarter Interim Feedback Dashboard Reports are now available for eligible professionals (EPs) who submitted data via claims between January 1, 2014 and June 30, 2014. The 2<sup>nd</sup> Quarter Interim Feedback Dashboard Reports allow EPs to access their 2014 PQRS data on a quarterly basis in order to monitor the status of PQRS claims-based individual measures reporting. The 2014 2<sup>nd</sup> Quarter Interim Feedback Dashboard Reports do not provide the final data analysis for the full-year reporting, or indicate 2014 PQRS incentive eligibility or subjectivity to the 2016 PQRS payment adjustment. Data submitted for 2014 PQRS reporting via methods other than claims will be available for review in the fall of 2015 through the final PQRS feedback report.

The [2014 Interim Feedback Dashboard User Guide](#) is designed to assist EPs with accessing and interpreting the 2014 interim dashboard data. If needed, please contact the QualityNet Help Desk for assistance at 866-288-8912 (TTY 877-715-6222) or at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

### **2013 PQRS and eRx Incentive Program Incentive Payments Available**

The 2013 Physician Quality Reporting System (PQRS) and 2013 Electronic Prescribing (eRx) Incentive Program incentive payments are now available for eligible professionals (EPs) and group practices who submitted data for Medicare Physician Fee Schedule Part B services between January 1, 2013 and December 31, 2013. The incentive payments are for EPs and groups practices who met the satisfactory reporting criteria, regardless of participation in another program (i.e., Medicare Shared Savings Program Accountable Care Organization, Comprehensive Primary Care Initiative, etc.).

As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS and eRx incentive payments made to eligible professionals and group practices have been reduced by 2%. This 2% reduction affected PQRS and eRx incentive payments for reporting periods that ended on or after April 1, 2013. All 2013 incentive payments are subject to sequestration.

For more information on the PQRS incentive payments, please review the [Analysis and Payment](#) web page. For more information on interpreting the data in the report, please review the [2013 PQRS Feedback Report User Guide](#). For more information on interpreting the eRx data in the report, check out the [2013 eRx Incentive Program Feedback Report User Guide](#). For more information on the eRx Incentive Program incentive payments, please review the [Analysis and Payment](#) web page. If needed, please contact the QualityNet Help Desk for assistance at 866-288-8912 (TTY 877-715-6222) or at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

### **2013 PQRS and eRx Incentive Program Feedback Reports Available**

The 2013 Physician Quality Reporting System (PQRS) and 2013 Electronic Prescribing (eRx) Incentive Program feedback reports are now available for eligible professionals (EPs) who submitted quality data on Medicare Physician Fee Schedule Part B services between January 1, 2013 and December 31, 2013.

Individual EPs who submitted 2013 PQRS data, or individual EPs and group practices who submitted 2013 eRx data, can retrieve their 2013 Feedback Reports through two methods:

- National Provider Identifier (NPI)-level reports: These reports can be requested through the CMS [Communication Support Page](#) by creating a NPI-level feedback report request. The report will be sent electronically to the email address provided in the request within two to four weeks.
- Taxpayer Identification Number (TIN) - level reports: These reports contain NPI level detail and are available for download on the [Physician and Other Health Care Professionals Quality Reporting Portal](#). To access a TIN-level report on the Portal, you must have an Individuals Authorized to Access CMS Computer Services (IACS) account. To request an IACS account in order to access the Portal, check out the [IACS Quick References Guides](#).

Group practices who participated in the 2013 PQRS Group Practice Reporting Option (GPRO) can access PQRS feedback through the 2013 Quality and Resource Use Reports (QRURs). The 2013 QRURs can be accessed by authorized representatives of groups and solo practitioners at: <https://portal.cms.gov> using a valid IACS User ID and password. For more information on the QRURs and Value Modifier, please access the [Physician Feedback Program/Value-Based Modifier](#) website.

For more information on interpreting the data in the report, check out the [2013 PQRS Feedback Report User Guide](#) and/or the [2013 eRx Incentive Program Feedback Report User Guide](#). If needed, please contact the QualityNet Help Desk for assistance at 866-288-8912 (TTY 877-715-6222) or via [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

#### ***September 26 - Clarification: 2013 QRURs Available Fall 2013***

The recently released *eNews* provided direction to access your 2013 QRUR. To clarify, the 2013 QRURs are not available at this time but will be available shortly. CMS will make available the 2013 QRURs for all physician group practices and solo practitioners nationwide. Please stay tuned for updates to the [Physician Feedback/ Value Modifier](#) website for announcements about the availability of the 2013 QRURs.

### **2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available**

The 2012 Electronic Prescribing (eRx) Incentive Program and 2012 Physician Quality Reporting System (PQRS) Supplemental Incentive Payments are now available for eligible professionals (EPs) who submitted data for the reporting period of January 1, 2012 through December 31, 2012 and met criteria for satisfactory reporting. 2012 eRx and PQRS Supplemental Incentives are provided to those EPs and group practices that submitted an Informal Review (IR) request that was approved by CMS. The eRx and PQRS incentives are 1.0% and 0.5% respectively of total estimated 2012 Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during reporting period. It is paid as lump sum to the Taxpayer Identification Number (TIN) under which the EP's claims were submitted.

For more information on interpreting the data in the report, check out the [2012 eRx Incentive Program Feedback Report User Guide](#) and the [2012 PQRS Feedback Report User Guide](#).

For more information on the eRx Incentive Program or PQRS incentive payments, please review the [eRx Analysis and Payment](#) and [PQRS Analysis and Payment](#) web pages. If needed, please contact the QualityNet Help Desk for assistance at 866-288-8912 (TTY 877-715-6222) or at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

## Completion and Submission Timeframes for Hospice Item Set Records

As part of the Hospice Quality Reporting Program (HQRP), all Medicare-certified hospices are required to complete and submit a Hospice Item Set (HIS)-Admission record and an HIS-Discharge record for patient admissions on or after July 1, 2014. Hospices should complete and submit each record according to the timeliness criteria outlined below:

- **HIS Record Completion:** The Completion Date is defined as the date all required information has been collected and recorded and staff have signed and dated that the record is complete. Hospices have 14 days from admission to complete HIS-Admission records and 7 days from discharge to complete HIS-Discharge records.
- **HIS Record Submission:** The Submission Date is defined as the date on which the completed record is submitted and accepted to the QIES ASAP System. Hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient to the QIES ASAP System.

If you have questions about completing and submitting the HIS, there are several resources available on the [HIS](#) web page. Providers should review the updated version of the [HIS Manual \(V1.01\)](#) as well as the two Question and Answer documents. A [Fact Sheet](#) regarding HIS completion timing guidelines and a [HIS Checklist](#) are also available. If you have any quality-related questions about the HQRP, please contact the Quality HelpDesk at [HospiceQualityQuestions@cms.hhs.gov](mailto:HospiceQualityQuestions@cms.hhs.gov).

The [HIS Technical Information](#) web page contains the final HIS data specifications and information related to software systems for HIS record completion and submission. In addition, hospices may want to review the Hospice Training Modules available on the [QIES Technical Support Office](#) website.

## Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape

Gain credits from Continuing Medical Education (CME) articles that focus on important skill sets in the current healthcare environment. Both articles are available on [Medscape.edu](http://Medscape.edu). To view the articles, you must be a registered Medscape user. There is no cost to join.

- [Physician Leadership in a Changing Healthcare Delivery System](#): Summarizes the leadership skills physicians need in an era of team-based care and quality-driven delivery system change.
- [Team-based Care in the Changing Healthcare Environment](#): This education program on team-based care defines essential elements, identifies factors that encourage use, and proposes strategies for practicing healthcare professionals to learn and apply principles.

## New Resources and Webinars from National Health IT Week

### *New Resources*

- [eHealth infographic](#) – Highlights the successes the eHealth programs, and how each program contributes to improved health care delivery
- [ICD-10 Medscape Education Resources](#) – Offer Continuing Medical Education/Continuing Education (CME/CE) credits to help providers prepare for the ICD-10 transition, including ICD-10: Getting From Here to There - Navigating the Road Ahead, ICD-10 and Clinical Documentation, and Expert Column: Preparing for ICD-10: Now Is the Time

### *Webinars*

CMS eHealth subject matter experts provided presentations and answered questions about different eHealth topics, including: ICD-10, [CMS and ONC Regulatory Updates](#), Administrative Simplification, and eCQMs. The webinar recordings and presentations will be available on the [eHealth events](#) web page shortly.

*Want more information about CMS eHealth?*

Make sure to visit the [eHealth](#) website for the latest news and updates.

## **PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting**

If you are [eligible to participate](#) in the 2014 [Physician Quality Reporting System \(PQRS\)](#), be sure to check out three new resources designed to make quality reporting simple. CMS has added beginner, intermediate, and advanced PQRS training modules to [eHealth University](#). Now you can find the information you need to help you satisfactorily participate in PQRS and other quality programs that offer incentive payments in 2014. The modules are designed by level for quick and easy use. Each module is divided into sections and provides helpful tips and graphics to explain different quality topics.

- [Quality Measurement 101](#) – A beginner module that provides the basics of quality reporting, specifically for PQRS.
- [2014 PQRS Reporting Requirements](#) – An intermediate module that explains the steps to satisfactorily reporting and earning an incentive for the 2014 PQRS program. The module also walks you through the steps on how to avoid the 2016 PQRS payment adjustment and the 2016 Value Modifier (VM) adjustment.
- [How to Report Once for 2014 Medicare Quality Reporting Programs](#) – An advanced module that explains how to report quality measures one time during the 2014 program year and satisfy quality reporting requirements for several Medicare quality reporting programs. These programs include PQRS, the Medicare Electronic Health Record (EHR) Incentive Program, the VM, and Accountable Care Organizations.

*Remember:* 2014 is the last year eligible professionals can earn an incentive payment for satisfactorily reporting PQRS quality data to CMS. This year's participation in PQRS determines the 2016 PQRS payment adjustment.

### *About eHealth University*

[eHealth University](#) is a tool to help providers find information and materials on each of the CMS [eHealth programs](#) in one location. To learn more about eHealth and eHealth University, watch this [introductory video](#).

## **2014 CAHPS for PQRS Survey**

Are you part of a group practice of 25 or more eligible professionals (EPs) participating in the Physician Quality Reporting System (PQRS) via the Group Practice Reporting Option (GPRO) in 2014? Consider using a CMS-certified survey vendor to supplement your PQRS reporting with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey.

The [2014 CAHPS for PQRS Survey](#) includes the core questions in the CAHPS Clinician & Group Survey (Version 2.0), plus additional questions to measure the following areas:

- Access to and use of specialist care
- Experience with care coordination
- Patient involvement in decision-making
- Experiences with a health care team
- Health promotion and patient education
- Patient functional status
- General health

### *CAHPS for PQRS Required for Groups 100+ Using Web Interface*

Unchanged for 2014 is the requirement for group practices of 100 or more EPs reporting via GPRO Web Interface to have the CAHPS for PQRS survey administered to their patients.

CMS will bear the cost of administering the CAHPS for PQRS survey to patients, regardless of reporting option (i.e., Web Interface, Qualified Registry, or Certified Electronic Health Record (EHR) Technology), for eligible group practices. *Note:* Group practices with an insufficient number of beneficiaries to produce reliable data may not be allowed to choose this option.

#### *New FAQs on CAHPS for PQRS*

To keep you updated with information on PQRS, CMS has recently added 5 new FAQs to the website. Review these FAQs for additional guidance on the CAHPS for PQRS survey:

- [What survey meets CMS' participation requirements for the 2014 PQRS?](#)
- [What is included in the CAHPS for 2014 PQRS patient survey?](#)
- [How are a group practice's patients identified and sampled for the CAHPS for 2014 PQRS?](#)
- [What is the cost of administering the CAHPS for PQRS survey?](#)
- [Is there a list of vendors approved to administer the CAHPS for 2014 PQRS or can my group practice participating via the GPRO submit the information?](#)

#### *For More Information*

Review the [2014 CMS-Certified Survey Vendor Made Simple](#) for the necessary criteria for using the CAHPS for PQRS survey or visit the [CMS-Certified Survey Vendor](#) web page. Make sure to visit the [PQRS](#) website for the latest news and updates on PQRS. You can also contact the QualityNet Help Desk at 866-288-8912 or at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

### **New PQRS FAQs Available**

To keep you updated with information on the Physician Quality Reporting System (PQRS), CMS has recently added two new FAQs to the website.

- [CEHRT Day 1 FAQ](#): This FAQ provides information regarding when Certified Electronic Health Record Technology (CEHRT) must be implemented to be successful for 2014 PQRS reporting.
- [2014 Registry XML NPI Validation FAQ](#): This FAQ provides guidance on the error message received when registries are submitting National Provider Identifiers (NPIs) for group practices participating via the group practice reporting option (GPRO) for 2014 PQRS.

#### *Want more information about PQRS?*

Make sure to visit the [PQRS](#) website for the latest news and updates on PQRS. You can also contact the QualityNet Help Desk at 866-288-8912 or at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

### **New and Updated FAQs for the EHR Incentive Programs**

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added one new FAQ and updated seven FAQs to the [CMS FAQ system](#).

#### *New FAQ:*

- For Measure 2 of the Stage 2 Summary of Care objective for the EHR Incentive Programs, may an [eligible professional, eligible hospital, or critical access hospital](#) count a transition of care or referral in its numerator for the measure if they electronically create and send a summary of care document using their Certified EHR Technology (CEHRT) to a third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document? [Read the answer.](#)

#### *Updated FAQs:*

- If my practice does not typically collect information on any of the core, alternate core, or additional clinical quality measures (CQMs) listed in the Final Rule on the Medicare and Medicaid EHR Incentive Programs, do I need to report on CQMs for which I do not have any data? [Read the answer.](#)
- Can eligible professionals use CQMs from the alternate core set to meet the requirement of reporting three additional measures for the Medicare and Medicaid EHR Incentive Programs? [Read the answer.](#)
- If one of the measures for the core set of CQMs for eligible professionals is not applicable for my patient population, am I excluded from reporting that measure for the Medicare or Medicaid EHR Incentive Programs? [Read the answer.](#)
- If none of the core, alternate core, or additional clinical quality measures adopted for the Medicare and Medicaid EHR incentive programs apply, am I exempt from reporting on all CQMs? [Read the answer.](#)
- If the denominators for all three of the core CQM are zero, do I have to report on the additional CQMs for eligible professionals under the Medicare and Medicaid EHR Incentive Programs? [Read the answer.](#)
- For the Medicare and Medicaid EHR Incentive Programs, if the certified EHR technology possessed by an eligible professional generates zero denominators for all CQMs in the additional set that it can calculate, is the eligible professional responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating? [Read the answer.](#)
- I am an eligible professional who has successfully attested for the Medicare EHR Incentive Program, so why haven't I received my incentive payment yet? [Read the answer.](#)

*Want more information about the EHR Incentive Programs?*

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

## Claims, Pricers, and Codes

### FDG PET for Solid Tumor Claims

Claims for Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors submitted between October 6 through November 10 will be held to ensure Medicare systems can accurately calculate payments. Specifically, these are claims containing Healthcare Common procedure Coding System (HCPCS) A9552 for all oncologic conditions. See [MLN Matters® Article MM8739](#) for additional information. These claims will be processed beginning on November 11 after the system has been fully tested. No action is required by providers.

## Medicare Learning Network® Educational Products

### “Medicare Billing Information for Rural Providers and Suppliers” Booklet — Revised

The “[Medicare Billing Information for Rural Providers and Suppliers](#)” Booklet (ICN 006762) was revised and is now available in downloadable format. To assist rural providers who have limited internet access, the “[Medicare Billing Information for Rural Providers and Suppliers Text-Only](#)” Booklet is available in text-only format. This booklet is designed to provide education on Medicare rural billing. It includes information for Critical Access Hospitals, Federally Qualified Health Centers, Home Health Agencies, Rural Health Clinics, Skilled Nursing Facilities, and Swing Beds.

### “Rural Health Clinic” Fact Sheet — Revised

The “[Rural Health Clinic](#)” Fact Sheet (ICN 006398) was revised and is now available in downloadable format. To assist rural providers who have limited internet access, the “[Rural Health Clinic Text-Only](#)” Fact Sheet is available in text-only format. This fact sheet is designed to provide education on Rural Health Clinics (RHC). It includes the following information: background, RHC services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, annual reconciliation, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

### “Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians” Fact Sheet — Revised

The “[Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians](#)” Fact Sheet (ICN 905645) was revised and is now available in a downloadable format. This fact sheet is designed to provide education for physicians on understanding how to comply with Federal laws that combat fraud and abuse and ensure appropriate quality medical care. It includes information on identifying "red flags" that could lead to potential liability in law enforcement and administrative actions.

### “Critical Access Hospital” Fact Sheet — Revised

The “[Critical Access Hospital](#)” Fact Sheet (ICN 006400) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Critical Access Hospitals (CAHs). It includes the following information: background, CAH designation, CAH payments (including hospital inpatient admission certification requirements), additional Medicare payments, grants to States under the Medicare Rural Hospital Flexibility Program, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

### Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

The [Medicare Learning Network](#)® is the home for education, information, and resources for health care professionals. Sign up for the electronic mailing lists below to stay informed of the latest Medicare Learning Network Educational Products and MLN Matters® Articles. You will receive an email when new and revised products and articles are released.

- [Medicare Learning Network Educational Products Electronic Mailing List](#): Medicare Learning Network Products are designed to provide education on a variety of CMS programs, including provider supplier enrollment, preventive services, provider compliance, and Medicare payment policies. All products are free of charge and offered in a variety of formats to meet your educational needs.
- [MLN Matters Articles Electronic Mailing List](#): MLN Matters are national articles that educate health care professionals about important changes to CMS programs. Articles explain complex policy information in plain language to help health care professionals reduce the time it takes to incorporate these changes into their CMS-related activities.

**[Is the eNews meeting your needs? Give us your feedback!](#)**

[Subscribe](#) to the *eNews*. Previous issues are available in the [archive](#).

Follow the MLN on [Twitter](#) #CMSMLN, and visit us on [YouTube](#).

