

Thursday, May 7, 2015

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## **MLN Connects<sup>®</sup> National Provider Calls**

## Medicare Acute Care Quality and Reporting Programs for Hospitals — Last Chance to Register

Tuesday, May 12; 1:30-3pm ET

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

Quality health care for people with Medicare is a high priority for the President, HHS, and CMS. HHS and CMS began launching Quality Initiatives in 2001 to assure quality health care for all Americans through accountability and public disclosure. The various Quality Initiatives touch every aspect of the health care system. This call will provide an overview of all Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs.

### Agenda:

- Hospital Inpatient Quality Reporting (IQR) Program
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Acquired Condition Reduction Program (HACRP)
- Hospital Readmission Reduction Program (HRRP)
- Electronic Health Records (EHR) Incentive Program
- Program alignment, goals, and conclusion

*Target Audience:* Hospital administrators, executive-level leaders, quality professionals, and staff new to quality reporting programs.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

## 2014 Mid-Year QRURs — Registration Now Open

Wednesday, June 3; 1:30-3pm ET

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

CMS released the 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) to physician solo practitioners and groups of physicians nationwide, including solo practitioners and groups with physicians who participated in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014. The 2014 MYQRURs were made available for informational purposes and contain information on a subset of the measures used to calculate the 2016 Value Modifier. This MLN Connects National Provider Call will provide an overview of the 2014 MYQRUR and explain how to interpret and use the information in the report. Learn more about the reports on the [MYQRUR](#) web page

The call will be more meaningful if you have your MYQRUR in front of you to follow along. Visit the [How to Obtain a QRUR](#) web page and access your report prior to the call.

### Agenda:

- Overview of the 2014 MYQRUR
- How to understand and use the 2014 MYQRURs
- Question and answer session

*Target Audience:* Physicians, practitioners, therapists, medical group practices, practice managers, medical and specialty societies, payers, and insurers.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

## **National Partnership to Improve Dementia Care and QAPI — Registration Now Open**

*Tuesday, June 16; 1:30-3pm ET*

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

During this MLN Connects National Provider Call, CMS subject matter experts will provide updates for the National Partnership and Quality Assurance and Performance Improvement (QAPI). Additionally, a nursing home will discuss steps taken to achieve antipsychotic medication reduction in their facility, and Indiana University will present information about evidence-based dementia care training. A question and answer session will follow the presentations.

The [National Partnership to Improve Dementia Care in Nursing Homes](#) and [QAPI](#) are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

### *Agenda:*

- National Partnership and QAPI updates
- Antipsychotic reduction success – The Cedars, Maine
- Evidence-based dementia care training

*Target Audience:* Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders

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

## **ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Registration Now Open**

*Thursday, June 18; 1:30-3pm ET*

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

It's not too late to get ready for ICD-10 implementation on October 1, 2015. During this MLN Connects National Provider Call, CMS subject matter experts will present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. A question and answer session will follow the presentations.

### *Agenda:*

- National implementation update and preparation strategies
- ICD-10-PCS Section X for new technologies
- Testing update
- Provider resources

*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 Audio Recording and Transcript**

The [audio recording](#) and [transcript](#) are now available for the April 21 call — *Medicare Shared Savings Program ACO: Application Process*. More information is available on the [call detail](#) web page. During this call, CMS subject matter experts covered helpful tips to complete a successful application for the Medicare Shared Savings Program, including information on how to submit an acceptable Accountable Care Organization (ACO) participant list, sample ACO participant agreement, executed ACO participant agreements, and governing body template.

## **CMS Events**

### **Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22**

*Deadline extended*

During the week of July 20 through 24, 2015, a final 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. CMS is accepting additional July volunteers from May 11 through 22, 2015. Don't miss your chance to participate in end-to-end testing with Medicare prior to the October 1, 2015, implementation date.

Approximately 850 volunteer submitters will be selected to participate in the July 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. *Note:* Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

*To volunteer as a testing submitter:*

- Volunteer forms are available on your [MAC](#) website
- Completed volunteer forms are due May 22
- CMS will review applications and select additional July testers
- The MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing by June 12

*If selected, testers must be able to:*

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC for set-up purposes by the deadline on your acceptance notice; testers will be dropped if information is not provided by the deadline.

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® Article #MM8867](#), “ICD-10 Limited End-to-End Testing with Submitters for 2015”
- [MLN Matters Special Edition Article #SE1435](#), “FAQs – ICD-10 End-to-End Testing”
- [MLN Matters Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach”

## **Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5**

To help you prepare for the transition to ICD-10, CMS offers acknowledgement testing for current direct submitters (providers and clearinghouses) to test with the Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor anytime up to the October 1, 2015, implementation date.

CMS previously conducted three successful acknowledgement testing weeks in [March 2014](#), [November 2014](#), and [March 2015](#). These acknowledgement testing weeks give submitters access to real-time help desk support and allow CMS to analyze testing data. Mark your calendar for the final acknowledgement testing week on June 1 through 5, 2015.

*Note:* [MLN Matters® Special Edition Article SE1501](#) explains the differences between acknowledgement and end-to-end testing with Medicare. For acknowledgement testing, all electronic submitters are encouraged to participate, even if you submit claims through a clearinghouse.

*How to participate:*

Information is available on your [MAC](#) website or through your clearinghouse (if you use a clearinghouse to submit claims to Medicare). Any provider who submits claims electronically can participate in acknowledgement testing.

*What you can expect during testing:*

- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system
- Test claims will be subject to all current front-end edits, including edits for valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and codes, including Healthcare Common Procedure Coding System (HCPCS) and place of service
- Testing will not confirm claim payment or produce a Remittance Advice (RA)
- MACs and CEDI will be staffed to handle increased call volume during this week

*Testing tips:*

- Make sure test files have the "T" in the ISA15 field to indicate the file is a test file
- Send ICD-10 coded test claims that closely resemble the claims that you currently submit
- Use valid submitter ID, NPI, and PTAN combinations
- Use current dates of service on test claims (i.e. October 1, 2014 through June 1, 2015)
- Do not use future dates of service or your claim will be rejected

*For more information:*

- [MLN Matters Article MM8858](#), “ICD-10 Testing - Acknowledgement Testing with Providers”
- [MLN Matters Special Edition Article SE1409](#), “Medicare FFS ICD-10 Testing Approach”

## Webinar for Comparative Billing Report on Transthoracic Echocardiography

Wednesday, May 27; 3-4pm ET

Join us for an informative discussion of the comparative billing report on Transthoracic Echocardiography (TTE) (CBR201505). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201505 is an educational tool designed to assist physicians with a specialty of cardiology or internal medicine, who submitted claims for office-based TTE services using Current Procedural Terminology (CPT) codes 93306, 93350, or 93351.

### Agenda:

- Opening remarks
- Overview of comparative billing report (CBR201505)
- Coverage policy
- Methods and results
- References and resources
- Question and answer session

### Presenter Information:

- Speakers: Craig DeFelice, Cyndi Wellborn, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

### How to Register and Event Replay:

- [Register](#)
- [Access a recording](#) of the webinar five business days following the event

## Announcements

### Proposed Updates to Hospice Wage Index and Payment Rates

On April 30, CMS issued a proposed rule ([CMS-1629-P](#)) that would update FY 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. As proposed, hospices would see an estimated 1.3 percent (\$200 million) increase in their payments for FY 2016. The \$200 million increase in estimated payments for FY 2016 reflects:

- The distributional effects of the 1.8 percent proposed FY 2016 hospice payment update (\$290 million increase)
- The use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (-0.7 percent/\$120 million decrease)
- The proposed implementation of the new Office of Management and Budget Core Based Statistical Area (CBSA) delineations for the FY 2016 hospice wage index with a one-year transition (0.2 percent/\$30 million increase)

The proposed rule also includes:

- Alignment of cap year
- Proposed routine home care rates
- Service intensity add-on
- Clarification of diagnoses on claim form

Public comments on the proposal will be accepted until June 29, 2015.

Full text of this excerpted [CMS fact sheet](#) (issued April 30).

## May is National Osteoporosis Month

Medicare provides coverage of, and payment for, Bone Mass Measurements (BMMs) for beneficiaries who meet certain eligibility and coverage criteria to identify bone mass, detect bone loss, or determine bone quality.

### *Medicare Coverage*

To be covered, a beneficiary must meet at least *one* of the following five conditions:

- Women determined by their physician or qualified non-physician practitioner to be estrogen deficient and at clinical risk for osteoporosis
- Individuals with vertebral abnormalities
- Individuals getting (or expecting to get) glucocorticoid therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than 3 months
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy

Medicare will pay for a screening BMM once every 2 years (at least 23 months have passed since the month the last covered BMM was performed) or may pay more frequently when medically necessary. The copayment/coinsurance and deductible are waived for this service; therefore eligible beneficiaries may receive this service with no out-of-pocket cost to them. Refer to the resources below for additional eligibility and coverage criteria.

### *For More Information:*

- Medicare Learning Network® “[Preventive Services](#)” Educational Tool
- [Medicare Benefit Policy Manual Pub 100-02, Chap 15, Section 80.5](#) Bone Mass Measurements
- [Medicare Claims Processing Manual Pub 110-04, Chap 18, Section 1.2](#) Table of Preventive Services and Screenings
- [National Osteoporosis Foundation](#), sponsor of National Osteoporosis Month

## Medicare Coverage for Viral Hepatitis

May is Hepatitis Awareness Month, and May 19 is Hepatitis Testing Day. The focus of these national health observances is to increase awareness of viral hepatitis and encourage priority populations to get tested. [Continue reading](#) to learn about payment for viral hepatitis immunization and screening services covered by Medicare.

## New CDC Measles Information and Resources

The Centers for Disease Control and Prevention (CDC) has new measles information and resources available. Visit the following CDC web pages:

- [Measles Cases and Outbreaks](#)
- [Map](#) showing the measles cases that are part of the large, multi-state outbreak linked to an amusement park in California
- [Measles](#) includes resources for health care providers, parents and care givers, and travelers

## **HHS Announces \$101 Million in Affordable Care Act Funding to 164 New Community Health Centers**

On May 5, HHS Secretary Sylvia M. Burwell announced approximately \$101 million in Affordable Care Act funding to 164 new health center sites in 33 states and two U.S. Territories for the delivery of comprehensive primary health care services in communities that need them most. These new health centers are projected to increase access to health care services for nearly 650,000 patients.

This investment will add to the more than 550 new health center sites that have opened in the last four years as a result of the Affordable Care Act. Today, nearly 1,300 health centers operate more than 9,000 service delivery sites that provide care to nearly 22 million patients – nearly 5 million more patients than at the beginning of 2009.

*For more information:*

- [List of award winners](#)
- [Health Resources and Services Administration Health Center Program](#)
- [Find a health center in your area](#)

Full text of this excerpted [HHS press release](#) (issued May 5).

## **Amendment to Disproportionate Share Hospital Ruling**

On April 22, CMS Ruling [1498-R2](#) amended CMS Ruling [1498-R](#), which affects Medicare Disproportionate Share Hospital (DSH) Payments under the Inpatient Prospective Payment System. View a short summary of the change in the “Note to Providers” section on the CMS [DSH](#) web page.

## **Inpatient Hospital Probe and Educate Extension**

On April 30, CMS announced plans to continue the Inpatient Probe and Educate process until September 30, 2015, and will continue to prohibit Recovery Auditor inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013, and September 30, 2015. Additional information is available on the [Inpatient Hospital Reviews](#) web page.

## **Quality Reporting Programs: Updated 2014 eCQMs for 2016 Reporting**

On May 1, CMS posted the annual update for the 2014 Electronic Clinical Quality Measures (eCQMs) for eligible hospitals and eligible professionals. Providers will use these updated measures to electronically report 2016 quality data for CMS quality reporting programs, including the Physician Quality Reporting System (PQRS), Inpatient Quality Reporting Program (IQR), and the Electronic Health Record (EHR) Incentive Programs. CMS updates the specifications annually to improve their alignment with current clinical guidelines and code systems so that they remain relevant and actionable within the clinical care setting. The updated measure specifications include:

- 29 updated measures for eligible hospitals
- 64 updated measures for eligible professionals

View and download the measures from the [eCQM Library](#). To obtain the value sets for the eCQMs, download packages in multiple file formats from the “Downloads” page at the [Value Set Authority Center](#).

## CMS Announces the Physician Quality Reporting Programs Strategic Vision

The [Physician Quality Reporting Programs Strategic Vision](#) describes a long-term vision for CMS quality measurement for physicians, professionals, and public reporting programs, and how they can be optimized and aligned to support better decision-making from doctors, consumers, and every part of the healthcare system. These programs support incentives to providers, encourage improvements in care delivery, and deliver information to consumers.

## ICD-10 Resources for Medicare Providers

CMS has [Medicare Fee-For-Service Provider Resources](#) to help you prepare for the transition to ICD-10 on October 1, 2015:

- Testing resources
- MLN Matters<sup>®</sup> Articles on billing, claims processing, the partial code freeze, Local Coverage Determinations (LCDs), and National Coverage Determinations (NCDs)
- Medicare Learning Network<sup>®</sup> Web Based Training Course on diagnosis coding using ICD-10-CM
- Medicare Learning Network products on billing, payment, coding, and General Equivalence Mappings
- MLN Connects<sup>®</sup> videos on coding basics, home health, testing, and the partial code freeze
- Resources, including links to calls, product ordering, and NCD conversion

## Five More Facts about ICD-10

*If you cannot submit ICD-10 claims electronically, Medicare offers several options*

CMS encourages you to prepare for the transition and be ready to submit ICD-10 claims electronically for all services provided on or after October 1, 2015. But, if you are not ready, Medicare has several options for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the provider be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every Medicare Administrative Contractor (MAC)
- In about half of the MAC jurisdictions, Part B claims submission functionality on the MAC's provider internet portal
- Submitting paper claims, if the Administrative Simplification Compliance Act waiver provisions are met

If you take this route, be sure to allot time for you or your staff to prepare and complete training on free billing software or portals before the compliance date.

*Practices that do not prepare for ICD-10 will not be able to submit claims for services performed on or after October 1, 2015*

Unless your practice is able to submit ICD-10 claims, whether using the alternate methods described above or electronically, your claims will not be accepted. Only claims coded with ICD-10 can be accepted for services provided on or after October 1, 2015.

*Reimbursement for outpatient and physician office procedures will not be determined by ICD-10 codes*

Outpatient and physician office claims are not paid based on ICD-10 diagnosis codes but on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, which are not changing. However, ICD-10-PCS codes will be used for hospital inpatient procedures, just as ICD-9 codes are used for such procedures today. Also, ICD diagnosis codes are sometimes used to determine medical necessity, regardless of care setting.

*Costs could be substantially lower than projected earlier.*

Recent studies by [3M](#) and the [Professional Association of Health Care Office Management](#) have found many Electronic Health Record (EHR) vendors are including ICD-10 in their systems or upgrades—at little or no cost to their customers. As a result, software and systems costs for ICD-10 could be minimal for many providers.

#### *It's time to transition to ICD-10*

ICD-10 is foundational to modernizing health care and improving quality. ICD-10 serves as a building block that allows for greater specificity and standardized data that can:

- Improve coordination of a patient's care across providers over time
- Advance public health research, public health surveillance, and emergency response through detection of disease outbreaks and adverse drug events
- Support innovative payment models that drive quality of care
- Enhance fraud detection efforts

*Keep Up to Date on ICD-10:* Visit the [ICD-10](#) website for the latest news and resources to help you prepare.

### **Medscape Article for CME Credit: Improving Quality of Care through Care Coordination**

Gain credits from a CME article on [Improving Quality of Care Through Care Coordination](#). The article focuses on:

- CMS programs aimed at improving care coordination and transitions
- Helpful, evidence-based strategies for providers to improve patient care coordination, including upcoming changes to billing and processes

All articles are available on [Medscape.edu](#). CMEs are also nursing accredited. To view the articles, you must be a registered Medscape user. There is no cost to join. Links to CMEs are also available through the CMS [Earn Credit](#) web page.

### **EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29**

CMS and the Office of the National Coordinator for Health Information Technology (ONC) invite the public to submit comments on the recently released proposed rules. The public can submit comments in several ways, including via electronic submission at [www.regulations.gov](#).

Due May 29:

- [Stage 3 of Meaningful Use](#) – Specifies the Stage 3 requirements for eligible professionals, eligible hospitals, and critical access hospitals in the Electronic Health Record (EHR) Incentive Programs
- [EHR Technology Certified to the 2015 Edition](#) – Outlines the certification and standards to help providers meet the proposed Stage 3 requirements with EHR technology certified to the 2015 Edition

Due June 15:

- Modifications to Meaningful Use in 2015-2017 – Proposes revised requirements for eligible professionals, eligible hospitals, and critical access hospitals participating in the EHR Incentive Programs in years 2015 through 2017

For more information on the Stage 3 and 2015 Edition certification criteria proposed rules, review the [press release](#) and [fact sheet](#).

## **FY 2016 Inpatient and LTCH PPS Proposed Rule: Comment Period Ends June 16**

On April 17, a proposed rule (CMS-1632-P) updating FY 2016 Medicare payment policies and rates under the Inpatient and the Long-Term Care Hospital (LTCH) Prospective Payment Systems (PPS) was displayed in the Federal Register. Comments are due by June 16. The *eNews* and CMS [fact sheet](#) listed the correct due date for comments; however the comment due date was incorrectly cited in the rule published on April 30, 2015. The Office of the Federal Register has issued a [correction](#).

## **CMS is Accepting Suggestions for Potential PQRS Measures**

*Measures submitted prior to June 15 may be considered for inclusion on the 2015 MUC list*

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. Quality measures submitted in this Call for Measures may also be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value-based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

As the PQRS Call for Measures is conducted in an ongoing open format, the month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015, at 5pm ET may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

CMS will give priority to measures that are outcome-based, answer a measure gap, and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is not accepting claims-based only reporting measures in this process. Note that measures already included in previous PQRS MUC lists may only be resubmitted for consideration if the measure has undergone substantive changes. Resubmission of measures with no significant changes made from the last submission will be automatically eliminated from the review process.

Each measure submitted for consideration *must* include all required supporting documentation. Documentation requirements and the submission timeline are posted on the [Measures Management System Call for Measures](#) web page. Questions about this Call for Measures or the required documentation may be submitted to [C4M@wvmi.org](mailto:C4M@wvmi.org).

## **Medicare Learning Network<sup>®</sup> Educational Products**

### **“The Medicare Home Health Benefit” Web-Based Training Course — Released**

“The Medicare Home Health Benefit” Web-Based Training (WBT) Course was released and is now available. This WBT is designed to provide education on Medicare home health services. It includes information on qualifying for home health services, consolidated billing, therapy services, billing, and payment. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access the WBT, go to [MLN Products](#), scroll to the bottom of the web page, and under “Related Links,” click on “Web-Based Training Courses.”

## **“Resources for Medicare Beneficiaries” Fact Sheet — Revised**

The “[Resources for Medicare Beneficiaries](#)” Fact Sheet (ICN 905183) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the variety of beneficiary-related publications available to assist providers in answering patients' questions. It includes a list of products with information you can print out and provide to your Medicare beneficiaries.

## **“Medicare Part B Immunization Billing” Educational Tool — Reminder**

The “[Medicare Part B Immunization Billing](#)” Educational Tool (006799) is available in downloadable format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding, and billing information on the influenza, pneumococcal, and Hepatitis B vaccines and their administration.

## **Medicare Learning Network<sup>®</sup> Products Available In Electronic Publication Format**

The following products are now available as electronic publications (EPUBs) and through QR codes. Instructions for downloading EPUBs and how to scan QR codes are available at “[How To Download a Medicare Learning Network<sup>®</sup> Electronic Publication.](#)”

- The “[Clinical Laboratory Fee Schedule](#)” Fact Sheet (ICN 006818) is designed to provide education on the Clinical Laboratory Fee Schedule (CLFS). It includes the following information: background, coverage of clinical laboratory services, how payment rates are set, and updates to the CLFS.
- The “[Long Term Care Hospital Prospective Payment System](#)” Fact Sheet (ICN 006956) is designed to provide education on the Long Term Care Hospital (LTCH) Prospective Payment System. It includes the following information: LTCH certification, Medicare Severity Long Term Care Diagnosis-Related Groups patient classification, payment policy adjustments, payment updates, and LTCH Quality Reporting Program.
- “[The Medicare Home Health Benefit](#)” Fact Sheet (ICN 908143) is designed to provide education on Medicare home health services. It includes the following information: qualifying for home health services, consolidated billing, therapy services, billing, and payment.

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