**Question:** I would like to obtain copy of new fee schedule for radiation therapy . . .

**Answer:** Medicare Fee Schedules are available at:
- [http://www.cgsmedicare.com/ohb/coverage/fees/fees.html](http://www.cgsmedicare.com/ohb/coverage/fees/fees.html) or
- To request a paper copy for a fee at:
  - Select Publications Order Form, fees applied based on your order.

**Question:** I have a question regarding claims-based reporting for 2014 PQRS. If we meet the measure Denominator on a patient who is in an Inpatient stay, does the date of service that is reported with the PQRS CPT code, to reflect the same date of service as the Code that caused the patient to be in the Denominator? We need to know if we were to use the specific date of encounter versus the discharge date of the patient.

**Answer:** Yes, the date should reflect the date of the encounter

1. QDCs must be reported:
   - a. on the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B PFS encounter for the same beneficiary for the same date of service (DOS) by the same eligible professional (individual NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.

2. When I printed off the 2014 Fee schedule I noticed a lot of the 2013 charges the pricing is a little bit more than what is for 2014. I have an email here that said it was suppose to be a 5.3% increase. So I am just not sure if this is the correct fee schedule or if it was revamped.

**Answer:** The fee schedule that's on our website is correct and the email (ListServ) that we sent out at the very end of December about the SGR Reform Act talks about and provides guidance on the overall 0.5% update. It's not 0.5% for everything. It's an overall 0.5% update. So that may vary a little by code.

**Question:** We’re an Independent Rural Health Clinic and I’ve seen some traffic about the venipuncture code now needing to be sent to our Part A contractor instead of our Part B contractor, can you comment on that?

**Answer:** Per MLN Matters article MM8504 page 2 of 3, fourth bullet:
- Although RHCs and FQHCs are required to furnish certain laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.

**Question:** The Medicare Education Modules are those free or is there a fee?

**Answer:** The Medicare Education Modules are free. You will have to setup an account (register) with CMS this will allow you take courses and receive continuing education credits.


**Question:** I’m receiving rejections for electronic claims with G codes for PQRS filing. I’ve been on the website and I cannot pull up anything that gives me a distinct difference between what is accepted in 2014 as in 2013. Where do I find those?

**Answer:** The PQRS measure documents for the current program year may be different from the PQRS measure documents for a prior year. Eligible professionals are responsible for ensuring that they are
using the PQRS measure documents for the correct program year. The 2014 PQRS CMS-1500 claim is an example of how an individual National Provider Identifier (NPI) reporting on a single CMS-1500 claim for 2014 PQRS should look.

**Selecting Measures for 2014 PQRS**

At a minimum, the following factors should be considered when selecting measures for reporting:

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2014
- Other quality reporting programs in use or being considered


**Question:** I have a question regarding the PQRS. On your handout it states that under registries you can report up to three measures to avoid the penalty with no incentive. Is that claim-based also? Or is that just registry, because right now we just report by claim base.

**Answer:** In 2014, if an EP or group practice does not satisfactorily report or satisfactorily participate while submitting data on PQRS quality measures, a 2% payment adjustment will apply in 2016. The adjustment (98% of the fee schedule amount that would otherwise apply to such services) applies to covered professional services furnished by an EP or group practice during 2016. Group practices taking part in PQRS through another CMS program should check the program’s requirements for information on how to simultaneously take part in PQRS as well as the other respective program to avoid the payment adjustment.

Individual EPs can avoid the 2016 PQRS payment adjustment by satisfactorily reporting or satisfactorily participating to earn a 2014 PQRS incentive payment (refer to Appendix 3 for submission requirements). Beyond meeting the criteria for the 2014 PQRS incentive payment, each submission method has its own minimum criteria for avoiding the 2016 payment adjustment.

**Reporting Criteria for Group Practices**

A group practice must have registered to report via qualified registry under the Group Practice Reporting Option (GPRO) for 2014 PQRS. Group practices can earn a 2014 PQRS incentive by meeting the following criteria for satisfactory reporting:

1. Report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least 50 percent of their group’s Medicare Part B FFS patients.
2. Group practices that submit quality data for only one to eight PQRS measures for at least 50 percent of their eligible patients or encounters for each measure, OR
3. Who submit data for nine or more PQRS measures across less than three domains for at least 50 percent of their eligible patients or encounters eligible for each measure will be subject to Measure-Applicability Validation (MAV).

**EPs can avoid the 2016 PQRS payment adjustment by meeting one of the following criteria:**

1. Satisfactorily report and earn the 2014 PQRS incentive.
2. Report at least 3 measures covering one NQS domain for at least 50 percent of the EP’s Medicare Part B FFS patients.
3. EPs that submit quality data for one or two PQRS measures for at least 50 percent of their patients or encounters eligible for each measure will be subject to MAV.


**EPs or group practices that satisfactorily report for only one to eight PQRS measures across one or more domains for at least 50 percent of their eligible patients or encounters for each measure, OR**

**EPs or group practices that satisfactorily report for nine or more PQRS measures across less than three domains for at least 50 percent of their eligible patients or encounters for each measure will be subject to Measure-Applicability Validation (MAV).**

**Reporting Criteria for Individual EPs**

EPs can earn a 2014 PQRS incentive by meeting one of the following criteria for satisfactory reporting:

1. Report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least 50 percent of the EP’s Medicare Part B FFS patients.
2. Group practices that submit quality data for one or two PQRS measures for at least 50 percent of their patients or encounters eligible for each measure will be subject to MAV.
Please refer to:

- Appendix 3 for above requirements.
- Eligible group practices taking part in the GPRO for the 12-month reporting period can avoid the 2016 PQRS payment adjustment by satisfactorily reporting to earn a 2014 PQRS incentive payment.
- See Table 6 of Appendix 2 or by meeting the criteria for avoiding the 2016 PQRS payment adjustment refer to Table 2 of Appendix 3 on the above link.
- Additional information on the PQRS payment adjustment can be found on the CMS.

To review the complete publication all details on Payment Adjustments for PQRS website at [http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html](http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html).

_Questions:_ I work in a small walk-in clinic. It’s not urgent care, we’re just convenience care. And it is run by a nurse practitioner. So is this something that we have to do?

_Answer:_ PQRS isn’t something that you have to do. However I will tell you that nurse practitioners are listed as an eligible professional which means they’re eligible for the incentive. And if they’re eligible for the incentive that may also mean that you could incur the penalty if you do not report. So it’s not really a have-to but it could be like a strongly encouraged. Does that help?

On Thursday, February 27, 2014 CGS will host a webinar that will explain PQRS in a little bit more detail how to access the measures and codes that are available and some questions you may want to ask yourselves as you’re thinking about what measures does it make sense for us to report? And then we’ll walk you through to how do those measures work in terms of the G codes? And what regular CPT and HCPCS codes do they have to be submitted with? Please watch for our ListServ on this upcoming event.