Centers for Medicare & Medicaid Services
2012 Physician Quality Reporting System and Electronic Prescribing Incentive Program Data Submission
National Provider Call
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time, I would like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Charlie Eleftheriou. Thank you, sir. You may begin.

Announcements and Introduction

Charlie Eleftheriou: Hello, this is Charlie Eleftheriou from the Provider Communications Group here in CMS, and I'll be serving as your moderator today. I'd like to welcome everyone to this Physician Quality Reporting System and Electronic Prescribing Incentive Program National Provider Call. Today's National Provider Call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers.

During today's presentation, we'll discuss 2012 program year data submission for the PQRS and eRx Incentive Program, specifically data submission through registry, electronic health record, and the group practice reporting option Web interface.

The presentation will be followed by a question-and-answer session, giving participants an opportunity to provide input and ask questions. Before we get started, I'd like to cover a couple things. There are—is a slide presentation for this session. The link to the presentation was e-mailed today to all registrants at approximately 12:00 p.m. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls mailbox.

Also, the presentation can be found by visiting www.cms.gov/npc, as in National Provider Call. Again, that's cms.gov/npc. Then click on the National Provider Calls and Events link on the left-side navigation panel, and you'll find today's call by date on the list.

Next, a reminder that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Physician Quality Reporting System and National Provider Call's Web pages on the CMS Web site. Also, we'd like to thank those of you who submitted questions when you registered for this call. Your questions were shared with the speakers to help prepare for today's call. Lastly, note that all pertinent resources and contact information related to the call are available on slides 28 and 29 of the presentation.

With all that said, I'll now turn the call over to Dr. Daniel Green.

Presentation

2012 PQRS Data Submission

Dan Green: Thanks, Charlie.

Since this is our first call of the new year, Happy New Year to everybody. Hope you had a great holiday season. I know that Charlie mentioned we're not going to be doing announcements anymore, but there are two important things that I do want to remind callers of today. The first has to do with the payment adjustment, which is scheduled to take place in 2015 for folks who do not participate in PQRS in 2013. So individuals, there's two ways you can get out of this. You can report at least one measure, by one of the reporting options, to CMS in 2013, or you can go onto our CSP, or Communications Support Page, and register—or elect to have administrative claims used for CMS to evaluate your—the quality of care that you're providing.

For groups of 100 or more, you guys would need to self-nominate to participate as a group. You could elect administrative claims as a group, or you could report through registries or the GPRO. You could—your eligible professionals could also report individually, but you would still need to go in for group purposes to self-nominate for administrative claims as a group, if your docs are reporting individually, because groups of 100 or more will not only be subject possibly to the 2015 payment adjustment for not participating in PQRS, but they also could be subject to a Value Modifier Program payment adjustment. And we really don't want to see any of our individual eligible professionals or group practices get dinged, if you will, in 2015 for something that they may have been able to avoid in 2013 by participating as I just mentioned.

So there's more information about that on our Web site. And, again, we would encourage you to look at that. If you have questions, please contact our QualityNet help desk for additional information.

So now on to a really important announcement, and that would be congratulations to the Ravens, who have made it to the Super Bowl. Sorry to gloat, but I will. OK. I'm getting dirty looks in the room.

Hopefully you all have had an opportunity at this point to open the slides that Charlie mentioned, which are posted on the Web site, so you all can follow along with today's presentation. If you look on slide 3, you'll see an overview of the agenda. We'll be talking about 2012 data submission for individual eligible professionals using a registry, EHR Direct, or EHR data submission vendor. We'll be talking about the GPRO Web interface, the 2012 eRx Incentive Program data submission also with those methods that were just mentioned; the Maintenance of Certification Program; and again, then there will be resources, as is the case of all of our presentations, in the back.

So if you look at slide number 5 now, you can see that even though we're in early 2013, you still have time to participate in the 2012 PQRS. And you can do that—obviously, it's too late to do that pretty much through claims, because you would have submitted all the claims for services you provided for the most part in 2012. Those would already be in, so

that you can work on getting paid. But you could still participate through a qualified registry or a qualified EHR Direct. So if your EHR software system—pardon me—is qualified to participate in PQRS, you could report directly from your EHR to CMS. And the neat thing about that is, obviously, you've already entered all the data that should be necessary when you documented the patient visiting your EHR. So if your system is qualified, it should be able to produce a report for whatever measures that you choose to report, and send that information in to CMS.

Now, it's not quite as simple as I just outlined. You would need to get an IACS account, which is a way to enter our PQRS submission portal to actually upload that data. But if your system, again, is qualified, you could work with your—with your vendor, and they would be able to help you and guide you through this process. Additionally, you can call our QualityNet help desk, and they can give you some additional information.

And then the last way, of course, is through a qualified EHR data submission vendor. A data submission vendor, for those that don't know, acts as a hybrid, if you will, between a registry and EHR Direct. So EHR data submission vendors get the quality information from—I'm sorry, they get the quality information electronically from an EHR, whereas a registry might get it from a Web portal, copy of claims, or a combination of those two methods, and—and from an EHR. Again, EHR data submission vendors only get it from an EHR itself.

So we would encourage you to look on our Alternative Reporting Option tab on our Web site. And you can look to see who the qualified registries, EHRs, and data submission vendors actually are, and you could reach out to them and see if it's too late, and perhaps to participate in 2012 PQRS.

Even though you would be submitting this information at this point, you could potentially qualify to receive a full-year incentive payment. It would also give you experience in reporting PQRS measures, which as I mentioned with the early announcement, you would definitely want to do in 2013 so that you can avoid a payment adjustment, which is scheduled to take place in 2015 for folks that do not successfully participate in 2013.

Looking on slide number 6, this slide outlines the data submission timeframes for the different methods to report. You see registries will start reporting in a little over a week, and they'll have until the end of March. Our EHR Direct and EHR data submission vendors, the reporting period is already open, and it will conclude on February 28th.

Looking on slide 7, so this slide talks a little bit about registry reporting, including starting off with what a registry is. And you know we use the term *registry* to define a vendor product that captures and stores clinically related data. So it's basically a data repository that also can send that data, if you will, to CMS.

The registries that are in our program are able to calculate the PQRS measures, and they transmit that data, again, to CMS on behalf of their eligible professionals in the specified format that CMS requires. Again, I mentioned earlier some of the different ways that

registries get data. Some of it has to do with manual data abstraction, copy of claims, so you may send a claim to your registry vendor. When you send in your billing claim, it may have a CPT–II or G code.

There's also registries that use Web portals to collect the information, so the eligible professional would go into the Web portal and, let's say, input the hemoglobin A1C for a particular patient that meets the measure, let's say. There's practice management software data mining, so if the registry has the capability, they can go into your billing software and say, "OK, tell me all the patients that are over age 65 that had this E&M service and had a diagnosis"—again, I'm going to pick on diabetes—"and had a diagnosis, let's say, of diabetes." So that would be your denominator cohort for the diabetes measures. And then all you have to do, then, is fill in the clinical information. You did do the A1C; you didn't do the A1C. It was in control or it wasn't in control.

Similarly, some registries can go into EHRs and data mine the information from an EHR. And, again, some registries use a combination of all-of-the-above methods. There's a Web link on slide 7 you can see is a list of our 2012 qualified registries, and the submission timeframe, as we mentioned, February 1st through March 31st of 2013.

So, steps for registry reporting: Again, I would go to our Web site, look under the Alternative Reporting tab, and you can see a list of the qualified registries. You can also see what each of the registries—which measures they can report, so whether they're doing measured groups, individual measures, you know, which measure groups they can do, etcetera.

You would want to select and contact your preferred registry. Your registry will ask you to enter into a legal agreement with them, and basically that allows them to receive patient data from you. They'll also ask you to sign a slip saying it's OK for them to transmit that calculated data, if you will, to CMS.

You will need to provide your TIN, your tax ID number, and your NPI number that you use to bill on your CMS 1500 form. You'll also need to provide them your individual NPI, and hopefully you're billing under your individual NPI, because that's what we'll look for to match it up in claims. Again, you would work directly with your selected registry. They'll provide you specific instructions about timing issues, how to upload the data, etcetera.

Looking on slide number 9, we'll talk for a minute about EHR Direct submission. So, EHR Direct vendors who are qualified—who are using a qualified EHR product and version. So that's important; you have to make sure the version that you're using of a particular vendor's software is a qualified version. You can use your system, again, to send the data directly to CMS.

So if you're participating in the PQRS Medicare EHR Incentive Pilot, in that case you would send—just like in the EHR Meaningful Use Program, you have to report on three core and/or alternate core, plus three additional measures. You would send them from

your CMS-qualified—or, I should say, PQRS-qualified EHR as well, as it would have to be, of course, certified by ONC for meeting Stage 1 Meaningful Use.

You do need the IACS account, and IACS is defined there: "Individuals Authorized Access to CMS" account. And it takes a little bit of time to get an IACS account number to be able to upload your information, so if you are interested in participating this way, we would encourage you to please try to get your IACS account as soon as possible.

Again, the timing for data submission is slightly different here. It's February—I'm sorry, January 1st through February 28th. And again, we had to have those dates a little bit earlier than you saw with the registry in an effort to meet our Meaningful Use requirements for our program there. Qualified EHR Direct vendors, you can see that, and the Web site is in—or the Web link is in the slides.

Looking on slide number 10, what is a qualified EHR data submission vendor? I think we talked about this. They collect the information—again, at least the numerator data—directly from the eligible professional's electronic health record. If they're participating in the pilot, they would submit an aggregate—an aggregate result for the Meaningful Use measures, and they would submit the individual QRDA 1, which is a data transmission specification, for the individual patient data. If they report both of those, and you're using a certified—ONC-certified system, you would get credit for both programs. The submission timing is the same for EHR Direct. And, again, there's a link there; you can see qualified data submission vendors on our Web site.

So looking at slide 11—or actually 12 now, I'm sorry—talks a little bit about the group practice reporting option. CMS selected group practices who wanted to participate in 2012 PQRS GPRO in the early part of 2012, using a self-nomination process. GPROs are analyzed at the tax ID level, under the tax ID which was submitted and provided at the time of the self-nomination.

If an organization or eligible professional changes tax ID numbers, the participation under the old TIN does not carry over to a new TIN, nor is it combined in any way for final analysis. So if you changed your TIN in the middle of the year, you're—we can't add the two together to come up with an aggregate result.

Looking on slide 13, GPROs were required to attend monthly meetings during the 2012 year with CMS, and the requirements for participation via the GPRO and the submitting data via the Web interface was discussed during many of these meetings.

To satisfactorily report 2012 PQRS through GPRO, you have to report—the groups would have to report on all measures included in the Web interface. And for those that don't know, the Web interface is an online tool that enables the group practice reporting option folks to answer specific quality measure questions for a prepopulated sample of their group's Medicare beneficiaries.

GPROs submit their 2012 Web interface data during the first quarter of 2013. So their submission period is—will be starting shortly, but is not quite started yet.

2012 PQRS GPRO abstraction occurs after the close of the 2012 calendar year. And if you look on slide 14, you can see that the group practice Web interface provides two methods of data abstraction. The group can manually enter the data for one patient at a time, or they can use an XML file to upload data for one or more patients. They can—the groups can combine the two methods, if it's easier for them and they choose to do so.

The prepopulated list of patients and other select data can be exported at the beginning of the submission period or at any time during the submission period. Exporting the data at the beginning of a submission period will provide information on all data that has been prefilled for the sample patients. Again, there's a Web link on slide 14 that will—you can go to—that will give you more information on our PQRS Web site regarding group practice reporting.

2012 eRx Incentive Program Data Submission

OK, so moving on now to the eRx portion of the talk, looking on slide 16. Good news is, you still have time to participate in the 2012 eRx Incentive Program. Again, if you're going to participate via registry—that would be a qualified registry, of course—if you're using a qualified EHR system or if you're going to use a qualified EHR data submission vendor.

Now, using the EHR Direct, I should point out, is not available for the 2012 eRx GPRO folks, but for individuals it would be fine. You may potentially qualify to receive a full-year incentive payment, so that would be a good thing, obviously, and you may potentially qualify to avoid the 2014 eRx payment adjustment.

So if you send in 25—if your registry or EHR data submission vendor, or even from your EHR itself if it's a qualified system, is able to report that you e-prescribed on at least 25 visits that appear in the denominator of the measure, you would not only potentially earn an incentive for 2012 of half a percent of your total PFS charges, but you also would avoid the 2014 payment adjustment. So that would be a really good thing.

And if you reported 10 times using claims in the first 6 months of 2012, you would avoid 2013 payment adjustment, 2014 payment adjustment (by virtue of doing the 25 for the year), and you'd get an incentive for 2012. So that would be like a triple-header. So we would encourage you, again, if you haven't, and you've done eRx for 2012, to please consider it as a way to earn a little extra money and also get out of the burden, if you will, of 2014 potential payment adjustment.

So looking on slide 17, the data submission periods, again, are listed below. I think we've talked about that. We do like folks to submit early and often, so if you're using EHR Direct, please try to submit as early as possible so if you have any problems your vendor and/or our help desk can work with you to get your data in successfully.

Looking on slide 18, this is kind of just what we talked about. And before, I said you may qualify for an incentive if you do 25 denominator-eligible patients—the reason I said you may qualify is, of course, 10 percent of your charges or more have to be comprised of codes that appear in the denominator of the measure. For more information, you can see the Web link, which is listed on the bottom of page 18—pardon me—and that will tell you more about the eRx program.

Looking on slide 19, we have the eRx GPRO reporting requirements. And as we talked about before with the self-nomination process, CMS did select group practices in 2012 who wanted to report eRx as a group, and that was all selected and confirmed through the self-nomination process. Groups of 100 or more eligible professionals had to report to us 2,500 e-prescribing events. For groups of 25 to 99 eligible professionals, they had to report at least 625 e-prescribing events.

Successful eRx GPROs, just like individuals, must have at least 10 percent of their group practice's Medicare Part B Physician Fee Schedule–allowed charges comprised of codes that appear in the denominator of the measure for the reporting period, which, of course, was the calendar year of 2012. There's additional information regarding eRx and GPRO reporting specifically of the electronic prescribing program, and that Web link is also on the bottom of page 19.

OK. Registry reporting for eRx, as you can see on slide—I'm getting ahead of myself—as you can see on the slide—that's slide 21. I'm sorry, I jumped ahead of myself. Registry reporting—actually on slide 20, there's another Web link for registry reporting, and it does list the qualified registries and go over the submission timeframe, which, again, as you've heard, is February 1st through March 31st for registries.

Looking on slide 21 now, here are the steps for registry reporting. Obviously, you'd want to contact your preferred registry. The same thing pretty much applies here as it did for PQRS reporting. Enter into the data the appropriate legal agreement, and also you'd need to sign a paper saying you can—that your registry can send that information to CMS. And, again, make sure you provide them the correct TIN and NPI number that you use to bill on your 1500 form, which hopefully is your—excuse me—individual NPI. Your registry will give you more instructions and specific instructions in terms of additional information they need from you once you speak with them.

EHR Direct—on slide 22, you see, as we've talked about a few times—does require that IACS account. And I mentioned it does take a little bit of time to get an IACS account, so the sooner you start, the better. You can find the qualified EHR Direct vendors, and whether or not they're qualified for eRx as well, on the link in the middle of page 22. Excuse me.

And data submission vendors, there's a link for those folks at the bottom of page 22. And, again, please note that the submission timeframe for EHR Direct and EHR data submission vendors is the same, meaning January 1st through February 28th, 2013, for the 2012 program year.

PQRS Maintenance of Certification Program

All right. So moving along to slide 24 now, we'll spend a minute talking about the Maintenance of Certification program. So this program allows physicians to have the opportunity to earn an additional PQRS incentive—I'm sorry, an additional PQRS incentive of half a percent. So folks have to participate successfully in PQRS, and if they do, they'll earn their PQRS incentive, but in addition, if they meet the Maintenance of Certification and their specialty board is participating, they would be eligible for an additional half a percent.

So satisfactory reporting of data without regard to method on quality measures for PQRS for a 12-month reporting period, either as an individual or group, would meet the PQRS requirement. And then the Maintenance of Certification requirement is not that you just are board-certified; you have to perform one or more of the activities of Maintenance of Certification, as defined by your board, more frequently than is required just to maintain your board certification. So if your board certification says you have to do A every 6 years or every 10 years to maintain board certification, they may say you have to do two times A or—again, I'm making this up, of course. But they'll set the bar a little bit higher that you—than what you would just normally have to do to maintain your certification. And if you do that and they participate with PQRS, they'll give us your name, tax ID number, and NPI, and you would be eligible if you satisfactorily participated in PQRS to earn an additional half a percent incentive payment.

So looking on slide 25, you can see a list of entities that are qualified for the 2012 PQRS MOC, or Maintenance of Certification Program, incentive. These folks have completed vetting to ensure that they represent the requirements for participation, and there's a Web link there in the middle of the page that will give you additional information and will also tell you the folks that are fully qualified MOCs. For MOC entities, they should reference the Maintenance of Certification Program incentive XML file specification, which—and that Web link is located at the bottom of page 25.

Looking on slide 26, the Maintenance of Certification entities submit data to CMS on behalf of their providers/specialty boards. Those folks also, of course, need to have an IACS account. And their submission period is February 1st through March 29th, so very similar to registry reporting submission.

So skipping ahead to slide 28, as promised, here are the resources where folks can look for additional information, and it includes the Web links as well.

On slide 29, you see our QualityNet help desk, where we have folks that can actually answer your questions. You can—when I say answer your questions, I mean a real person to answer them, instead of a FAQ, for example. So you can feel free to contact these folks. The phone number, the e-mail, etcetera, are listed on this page. You see their hours of operation are 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday. Please note that the closer we get to the submission deadline for these different methods of reporting, the busier this help desk is going to be. So, again, my final plug for submit early and submit often.

On slide 30, you can see a list of the acronyms that I may have used during this brief discussion, so—if you have any questions about that. And then we would ask that you guys evaluate your experience, but I'm going to let Charlie talk more about that. So let me turn it over to Charlie, before we break into the question-and-answer session. Thank you for your attention.

Keypad Polling

Charlie Eleftheriou: All right. Thank you, Dr. Green.

At this time, before we move into the question-and-answer session, I'd like to conduct keypad polling in order to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. We're ready to start polling now.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Charlie Eleftheriou: And while we're holding, let me just take this time to remind everyone before we go into Q&A, that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. Also, in an effort to get to as many of your questions as possible, we ask that you limit your questions to one at a time. If you have more than one question, press star 1 after your initial question, and it'll put you back into queue and we'll address your additional questions as time permits.

We'll be ready to take our first question-and-answer—I'm sorry, we'll be able to take our first question when keypad polling is finished.

Operator: And this does conclude the polling session of today's call. We'll move into the Q&A session. To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Lesa Roberts.

Question-and-Answer Session

Lesa Roberts: Hi, Lesa Roberts with Cotton O'Neil Revocable Trust, Topeka, Kansas. I had submitted a question regarding the addition of a practice group to our TIN this year. That group had prior—had been previously using the PQRI reporting through registry, and now they are part of our group, and we have been using GPRO. I would like some direction on which they would be counted in for calendar year 2012.

Dan Green: So, hi, this is Dan. A couple of things: First of all, are they reporting still under their old TIN through the registry for the first part of the year?

Lesa Roberts: I am not entirely sure, but I would assume so.

Dan Green: OK, so for that part, they would be treated as if—let's say they had 100 patients in the first 4 months of the year before they switched to you, for example. If they reported through a registry, they would be treated as—they would be looked at over those 100 patients, if you will, and if they earned an incentive by reporting on 80 percent of the patients—you know, via the registry—they would get an incentive, you know, for their PFS charges for the first 4 months of the year.

Now, as far as the GPRO aspect, I'm going to have to defer that to Regina or Molly.

Molly MacHarris: Sure. This is Molly. So did you—did your group self-nominate as a GPRO for 2012?

Lesa Roberts: Yes, we did.

Molly MacHarris: OK. And the providers who used to practice under another TIN, now you're saying they're practicing under your TIN, your GPRO?

Lesa Roberts: That's correct. They joined our TIN August 1st.

Molly MacHarris: OK. So those providers, they—that are now part of your TIN, they would be included for the latter part of the year as participants in your group practice. And as you prepare to do your submissions in the next couple of weeks to months, there could be some of those providers' beneficiaries in the patient sampling that you'll see when you submit your data through the Web interface.

Lesa Roberts: OK. I just wanted to be sure of that. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Annette LaCasse.

Annette LaCasse: Hi. We have a question regarding the measure 265. And we are trying to submit it, but we are only using the G8884, and they're saying we need another option.

Dan Green: Are our PMBR colleagues on the call, by chance?

Female 1: Yeah PMBR's here, Dr. Green.

Annette LaCasse: Pardon me?

Dan Green: Great. I'm sorry, we don't have a measure specification book with us. If you're able to check that out, please?

Female 1: Yeah, we'll definitely check that out. So I think what we'll do—if that's OK with you—is I'd like to open a—go ahead and get a QualityNet help desk ticket—open a new—because your measure—or you're referencing biopsy follow-up measure. Is that correct?

Annette LaCasse: Yes, okay.

Female 1: And you are—are you reporting this specification via claims or registry?

Annette LaCasse: Registry.

Female 1: OK. So then you're trying to report the encounter code of which code?

Annette LaCasse: 265. And we're using the G8884, but it's saying we need at least one of the G8883, but according to our instructions, there's a big "or." It didn't sound like we needed to use one and then the rest of the other.

Female 1: Right. So you're trying to—you're giving the exclusion criteria for that measure.

Annette LaCasse: Yes.

Female 1: So your registry is not accepting that code...

Annette LaCasse: Right.

Female 1: ... or... ?

Annette LaCasse: Right. It's saying that we need one of the other—the G8883, I'm assuming.

Female 1: OK, so I think I would—I think I'd like to pull this question offline and maybe discuss this with you a little bit more thoroughly. How about—and I'm—please help me out here, folks on the call. What is the best way to get Annette's information so that we can create a help desk ticket for her?

Female 2: I'm sorry, can you repeat that question?

Female 1: What is the best way to get Annette's information so that we can keep her information private, but open a help desk ticket for her?

Charlie Eleftheriou: If she would like to e-mail her information to the fee-for-service provider relations resource box, the e-mail address is ffs, as in fee-for-service, ffsproviderrelations, with no spaces, @cms.hhs.gov. This is not an e-mail address to submit general questions; this is just for this caller to submit her contact information so we can follow up.

Annette LaCasse: OK, so that's ffsproviderrelations@cms...

Charlie Eleftheriou: Yes, yes.

Annette LaCasse: At cms—what was the rest of that?

Charlie Eleftheriou: Oh, .gov.

Annette LaCasse: OK. OK. So I should do that after the call?

Charlie Eleftheriou: Also, she could always call the toll-free phone number that's found on slide 29—that's actually probably a better option—the QualityNet help desk.

Annette LaCasse: OK.

Charlie Eleftheriou: It's 866-288-8912.

Dan Green: This may end up just being a registry issue that needs to be corrected and clarified with the registry that you're using, but they'll be able to do the background work to find out and assist you more timely.

Operator: And your next question comes from the line of Mary Koval.

Mary Koval: Hi, this is Mary Koval at Weill Cornell Physician Organization. We are a group of over 100 physicians, and I just wanted to clarify the statement, or make sure that I'm getting this right. As a group, if we submit a nomination form for administrative claims option, we will not only avoid the 1 percent Value-Based Modifier penalty, but we will also avoid the 1.5 percent PQRS penalty in 2015. And we can also submit individually PQRS measures and receive the incentive. Is that correct?

Molly MacHarris: This is Molly. Yes, that's correct. You would...

Mary Koval: OK, good.

Molly MacHarris: ... need to submit your self-nomination statement during the summer timeframe.

Mary Koval: Yes, okay.

Molly MacHarris: We will be providing additional information on that exact Web site link and how to submit that statement a little bit later in the year.

Mary Koval: OK, great. I'm sorry. Go ahead.

Dan Green: I'm sorry. Just so you know, so, you know, let's say you do the first two things you said—you submit the—you elect administrative claims for your group and you self—I'm sorry, you elect administrative claims, so that gets you out of the PQRS payment adjustment as well as the Value Modifier adjustment.

And then not all of your—I mean, we would encourage you to have all of your eligible professionals, obviously, participate individually in PQRS, but those that do and are successful, obviously, would earn an incentive. If only half your group does, then only half the group will get the incentive.

Mary Koval: OK.

Dan Green: But the whole—the whole group would be protected from the adjustments.

Mary Koval: Oh, great. OK, very good. Thank you very much.

Dan Green: Thank you.

Mary Koval: Bye-bye.

Operator: Your next question comes from the line of Brandon Todd.

Brandon Todd: Yeah, this is Brandon Todd, Wilmington Ear, Nose and Throat Associates in North Carolina. And my question is, we just got on our EHR in April of 2012. And would we be able to do the PQRS submission just for that period? Or is that too short of a timeframe?

Dan Green: Just give us one second. So one thing that you could do is you could try to report using a registry for this particular year, since you wouldn't have a full 12 months. I mean, because in the spirit of things, you wouldn't have necessarily the 4 months of the—I'm sorry, the patients that you saw in the first 4 months necessarily in your EHR.

You might have them in, obviously, if they've come in for a subsequent visit during the course of the year.

But that's where the issue kind of comes in—comes in, because we're looking for 80 percent reporting on the patients for the year. And your reporting period would be only 8 months.

Brandon Todd: Got you. OK.

Dan Green: So you could—but you still could report through a registry, because a registry may be able to get the information from your EHR, and then, you know, part of the information you would provide perhaps through your Web portal. And it may be, in fact, that, you know, all your patients were seen twice during the year—and when I say all, I mean at least 80 percent of them were seen during—twice during the year, which includes the last 8 months of the year, in which case, you know, if you do some sort of data run, see if that occurred, that at least 80 percent of the patients occurred in the last 8 months, if your system's able to do that. Then you could actually even report using EHR.

Brandon Todd: OK.

Dan Green: Good question.

Operator: Your next question comes from the line of Jolene Eicher.

Jolene Eicher: Yes, this is Jolene.

Male: Hi.

Male: Hi.

Jolene Eicher: I have a question about eligible providers, my audiologist in particular. If they successfully report on one measure in 2013, is that sufficient to avoid the payment adjustment in 2015?

Molly MacHarris: This is Molly. Yes, based off of the criteria that we finalized in the 2013 Physician Fee Schedule rule. For purposes of the 2015 PQRS payment adjustment, eligible professionals can report one measure to avoid that payment adjustment. We do, however, strongly encourage all eligible professionals to report on the incentive eligibility criteria, because we did indicate in the rule that we view the 2013 criteria for the payment adjustment as an introductory period to get more eligible professionals participating in the program. So while there is still time, we do strongly encourage those EPs to start selecting their measures and reporting on more than one.

Jolene Eicher: OK. But as long as they report successfully on one, do they—will they be subject to that MAV review at all, that looks at whether or not they should have reported on more than one measure?

Dan Green: Not for the payment adjustment.

Jolene Eicher: OK, that's for the incentive.

Dan Green: To earn an incentive, they would be.

Jolene Eicher: OK. That clarifies it. Thank you.

Dan Green: Thank you.

Operator: Your next question comes from the line of Alice Kater.

Alice Kater: Good afternoon. Thank you for taking my call. I have a question with regard to the fact that we are a small urology practice. We participate in PQRS via claims-based submissions. We have successfully attested to EHR and will be attesting to Stage 1, Year 2 coming in February.

My question is twofold. It is my understanding that with reimbursement for EHR attestation, we could no longer obtain incentives for our PQRS submissions. Is that correct?

Dan Green: No. You can get a Meaningful Use incentive, as well as a PQRS incentive. They're not mutually exclusive. I think what you're referring to or maybe confusing just a little bit is the fact that you cannot get a Meaningful Use incentive and an e-prescribing—excuse me—a Medicare e-prescribing incentive payment.

So if you're doing Meaningful Use under the Medicare program, you can't also get a Medicare eRx incentive. If you were doing Medicaid Meaningful Use, you could still get a Medicare eRx incentive. But PQRS and Meaningful Use are not at all mutually exclusive.

Alice Kater: All right. Thank you. Then, my second question, or the second part is, I believe I heard you say that successful PQRS participation in order to get the reimbursement was requiring participation in six measures. Is that correct?

Dan Green: No. What I was referring to is, if someone were trying to participate in the PQRS EHR Pilot program, whereby they report, let's say, directly from their electronic health record for both programs using the same data, if they report the three core measures plus three additional measures, they could get credit from a qualified/ONC-certified system. They could get credit for both programs with one reporting.

But if you're doing what you're doing with the attestation, you would go into the national-level repository, do your attestation, enter that information, and then you only need to report on either one measures group successfully or three individual measures.

Alice Kater: Three, all right. And then if we have successfully participated in PQRS—we've been doing this since 2007, but for some reason we didn't hear anything last year, so we should be checking up on that, I would assume?

Dan Green: You say last year, do you mean for 2011 or you mean 2012?

Alice Kater: For—I'm sorry, for 2011. We didn't hear anything in 2012 for 2011. So, I am assuming that we need to check further on that. We just kind of let it slide because we thought—because we attested at the end of 2011 for 2012, that the monies were absorbed.

Molly MacHarris: This is Molly. For 2011, the PQRS incentive payments, they have been distributed. Those actually went out around September or October of 2012.

Alice Kater: OK.

Molly MacHarris: So what you can do is we do provide feedback reports, and if you go to the home page of the PQRS portal—I believe it is www.qualitynet.org/pqrs—on the lower left-hand corner there is a box, and you can enter your TIN or your NPI, and you can find if you have a feedback report.

You can also contact the QualityNet help desk, and again, their information is on slide 29. And they can walk you through that process of obtaining your feedback report so you can see what happened with your 2011 PQRS payment, if you met the incentive eligibility criteria, and if you actually did already receive that payment.

Alice Kater: OK. Well, I thank you very much. One thing I do want to comment on is through the years, we have had nothing but difficulty getting onto—utilizing IACS. I'm hoping at some point it will be less prohibitive. Just a comment. Thank you very much for your time.

Molly MacHarris: Thank you.

Dan Green: Thank you.

Operator: And your next question comes from the line of Sara Nied.

Sara Nied: Hi, this is Sara Nied calling from Atkinson Family Practice. I am so glad I came right after Alice because my question has—is very similar to hers, in that we have been doing PQRI—as we know it, for us old people—or PQRS. And I did get my 2011 reports just recently because, again, we did the attestation, and we thought—again, we kind of let it slide like we probably shouldn't have.

And my reports—I got my reports because I had to call the help desk, and my reports actually said "reporting requirements met," "NPI ineligible due to earning Medicare EHR incentive."

Molly MacHarris: So that should only apply for the e-Prescribing Incentive Program. As Dr. Green mentioned earlier, there is an overlap between the e-Prescribing Incentive Program and the Medicare EHR Incentive Program, whereby…

Sara Nied: And that's what I wrote down when he said that, yes. Because that's what is says: "incentive detail for eRx measure." Sorry, I should have mentioned that.

Molly MacHarris: OK, so for the e-prescribing program, if you—so if you're—if you meet the satisfactory reporting requirements for both Medicare EHR Incentive Program and the e-Prescribing Incentive Program, you would receive the Medicare EHR Incentive Program bonus, because for really the majority of physicians the monies that you would receive under that program significantly outweigh what you would receive under the e-Prescribing Incentive Program.

Sara Nied: OK.

Molly MacHarris: But one of the nuances that we always encourage providers to report on e-prescribing is because you could still be assessed the e-prescribing payment adjustment.

So if you did get the Medicare EHR Incentive Program bonus, and your report says that you're ineligible for the e-prescribing incentive because of that reason, that is accurate. But you can, of course, always call the help desk. Again, their info is on slide 29, and they can explain this to you in a lot of detail, probably more than you want to know.

Sara Nied: Well, I'm hoping so because I couldn't get an IACS number, so they gave me these individual reports. And we do submit under a group number, so that's why I was also confused.

Molly MacHarris: Yes. So we do have two ways that you can access your feedback report. We have the individual report, where the NPI—on an NPI basis they can actually go in, request their feedback report, and it will be e-mailed to them within a couple of weeks.

To get the…

Sara Nied: That's how I got them, yes.

Molly MacHarris: Yes. To get the group-level report, which is at your tax identification number—so let's say your practice has one TIN with, you know, 150 providers, it would make sense to go ahead and get the IACS account so you can access that feedback report

at the TIN level, because it will show an NPI-by-NPI breakdown on which providers actually met the e-prescribing…

Sara Nied: Oh, and I've gotten that in years past, and this year I tried to do it, and they said they couldn't find my providers, which is—was really frustrating. I attempted to get it, like, four times.

Molly MacHarris: OK, and you spoke with the help desk, and they weren't able to assist you?

Sara Nied: Yes. And they advised me just to get the reports this way, and then my reports just said insufficient number of measures on the Physician Quality Report. And then when you go to the measures, it says "denominators–182, numbers reported–178." It says there weren't enough and I just don't understand it.

Molly MacHarris: OK. I think what will be best is if—at this point if we can get your name and your phone number, and we will have the help desk pull all your ticket history for us, and we'll be able to look into what happened. And you'll be hearing back either from someone here at CMS or someone from the help desk who can explain to you in more detail exactly what happened in your situation.

Sara Nied: OK.

Molly MacHarris: So if you can give us your name and phone number, we can have someone follow up with you.

Sara Nied: Sure, OK.

Molly MacHarris: OK, go ahead.

Sara Nied: It's Sara, S-A-R-A, Nied, N-I-E-D, and it's 413-549-8400.

Molly MacHarris: OK. All right, thank you, Sara.

Sara Nied: Don't everyone go calling me. No, I'm just kidding.

Molly MacHarris: Well, thank you.

Dan Green: Only to gloat about the Ravens.

Sara Nied: All right, you know, Patriots didn't do so well so, you know, I'm not going to say anything.

Dan Green: We'll call Sara back right away of course, now.

Sara Nied: Thank you.

Operator: And your next question comes from the line of Kim Sweet.

Kim Sweet: Hi. This is Kim Sweet from Scroggins Associates in Ohio, and my question has to do with the Maintenance of Certification Program. I just wonder, is that available just for 2012, or is that going to be for 2013 as well? Do you know?

Molly MacHarris: This is Molly. It will be available through 2012, 2013, and 2014. So if you or your physician participates in the Maintenance of Certification Program, they can actually earn an additional half a percent incentive. The prerequisite is that they have to meet the PQRS incentive eligibility requirements first.

So first they have to be PQRS incentive–eligible, and then if they do the additional items for participation in the MOC program, they can get that additional half a percent incentive.

Kim Sweet: OK, thank you very much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Shelly Crotty.

Shelly Crotty: Yes. I wanted to ask if the EPs that are participating in the direct EHR submission will be penalized if they are unable to submit due to vendor issues by February 28th. And additionally, do you plan on extending that deadline past February 28th?

Dan Green: Hi, this is Dan. So unfortunately we really have a die-hard hard stop on the 28th. We really would love to be able to extend it, because we obviously want to encourage as many folks as possible to get their information in, and we're excited about this method of reporting particularly. But unfortunately, due the constraints of other programs here at PQRS—I'm sorry, at CMS (PQRS on the brain), we can't extend that time period. We would encourage you if you are having vendor issues to please work with your vendors. If you're having problems, of course you can call our QualityNet help desk, and they've been working with the vendors that have been having issues.

You won't get penalized—well, you won't get penalized in terms of a payment adjustment, you know, in 2015 like we've been talking about, because your reporting through the end of February is for 2012. But you could—the "penalty," so to speak—I'll put that in quotes—that you would potentially face is you wouldn't earn the incentive that you might have otherwise been entitled to.

We obviously don't want to see that happen, so please, again, you know, open a QualityNet ticket if you're having problems with your vendors. We have calls once a month with vendors; we're happy to reach out to them even outside of those calls if there's anything we can do, of course, to try to facilitate your process.

Shelly Crotty: OK, thank you.

Dan Green: Thank you.

Operator: Your next question comes from the line of Mariela Duncan.

Female: There you go; you're on.

Mariela Duncan: Hello, yes. I just have a quick question. On measure number 249, which is for Barrett's esophagus, we want to clarify if there is no diagnosis of Barrett's, should the measure 3125F 1P be submitted for all other esophageal biopsies?

Molly MacHarris: This is Molly. PMBR, can you guys answer that question?

Female: Hi, Mary. This is PMBR. In regards to that, if the diagnosis is not—you're submitting via claims?

Mariela Duncan: Yes.

Female: So your claim form would have to have both the diagnosis and the appropriate pathology code on that claim. Are you coding…

Mariela Duncan: Right.

Female: OK. So then if you're coding it on your claim, you're sure that this—I mean, are you saying then the pathology biopsied—this patient doesn't have Barrett's?

Mariela Duncan: That's right. So they're evaluating an esophageal biopsy, and when they look at it, they determine that it is not Barrett's. They would say that there is no dysplasia present, and they would diagnose it as whatever, you know, esophagitis versus Barrett's.

So I know for 3125F we would have to have, yes, a diagnosis of Barrett's and a statement about dysplasia, and we would have reported the right code. What we're trying to figure out is for all other esophageal biopsies that in fact are not Barrett's, should we be reporting the 1P?

Female: So 3125F with 1P would be acceptable, as this patient is not truly meeting the intent of the measure.

Mariela Duncan: That's right.

Female: In the way that you're coding the claim I see that, you know, these patients are coming in, and I'm imagining that on the front side when you're creating this claim form that, you know—is it the referring physician who is assuming that it's Barrett's and then

once you have the biopsy complete, the pathology report, then that's when they make the determination? Is that how that Barrett's esophagus diagnosis code is…

Mariela Duncan: Yes. They would send in an esophageal biopsy, and they'd say, "rule out Barrett's." So they may clinically think that it is Barrett's, but upon review of the biopsy, in fact it is not Barrett's.

Female: OK. All right, well, thanks for explaining that. I appreciate that. So, yes, I believe the 1P would be the most appropriate response.

Mariela Duncan: OK, because the diagnosis then, of course, would not be 530.85. It's going to go in under whatever they actually found.

Female: So would you change your claim form at that point, once you realized that it's not Barrett's?

Dan Green: Excuse me, sorry to interrupt.

Mariela Duncan: We would have…

Dan Green: Can we—PMBR, do you mind getting her phone number and contacting her back, please, and maybe you guys can take a little more time to… ?

Female: OK.

Mariela Duncan: You ready?

Female: Yes, I'm ready.

Mariela Duncan: OK. 305-238-7939.

Female: OK, thanks so much. I'll give you a call later.

Mariela Duncan: Thank you.

Female: Yes.

Operator: Your next question comes from the line of Marty Sheber.

Marty Sheber: Hi there, can you hear me?

Male: Yes.

Marty Sheber: OK. Thanks for taking my call here. I just have some, I guess, a clarification on when I got our 2011 feedback reports—no—yes, 2011 for 2012—for two of our providers. One's a P.A. and one's a physician. It said that they were subject to the

2013 payment adjustment. But we had also, I guess, before then filed a hardship exemption. What is an easy way to know whether or not we qualified for that exemption or not?

Lauren Fuentes: Hi, this is Lauren. I think probably the best way is for you to go ahead and call the help desk, because those 2011 reports only took into consideration your reporting during the 20—year—11, so it wouldn't necessarily take into effect your hardship exemption request.

Marty Sheber: OK. So if I just call the QualityNet help desk they should be able to just tell me over the phone?

Lauren Fuentes: They know who's subject and they should be able to tell you that.

Marty Sheber: OK, all right then. That's it, thank you so much.

Male: Thank you.

Operator: And your next question comes from the line of Jennifer Montgomery.

Jennifer Montgomery: Yes, hi. This is Jennifer Montgomery from Beth Israel–Continuum Medical Center in New York. It's kind of a twofold question regarding the PQRS EHR pilot, and I'm wondering if in order to do both, do we need to report for the EHR for the full calendar year as well? And then does it delay payment for the EHR incentive to meet with the PQRS payments?

Dan Green: So, this is Dan. Good question. If you're trying to participate in the pilot, yes, we do ask for a full year of reporting on CQMs. So if you're in Year 1 of Meaningful Use, which may entitle you to a 3-month reporting period for the other metrics, you would end up having to submit a whole—excuse me—a year of quality measures.

So for example, if your 3 months were February through May, let's say, you'd have to wait and report the whole year, and that reporting period would be January and February of the following year. So yes, it would delay your payment. Again, if you're Year 1. If you're Year 2 or beyond, then the reporting period is more than 3 months, it's for a whole year; so then you'd still be in sync.

Jennifer Montgomery: Right. But you couldn't split that, right, in terms of providers? You'd have to either-or?

Dan Green: I'm not 100 percent sure I'm following the last part of your question.

Jennifer Montgomery: Well, we have groups of doctors, and some have been already in Stage 1, Year 1, but we have—will be attesting for more folks now this year for Stage 1, Year 1, but I would have to, if I'm in the pilot, do both?

Dan Green: No. So the pilot and your reporting, as long as you're not part of a GPRO, you know, is on a doctor-by-doctor basis. So if Doctor A is…

Jennifer Montgomery: Oh, it is. OK, all right.

Dan Green: … is in Year 2 of his or her Meaningful Use, and so they have a full-year reporting, you could participate in the pilot for that doctor. And Doctor B, let's say, is Year 1, so they only have 3 months. So you could go in and just do all the attestation and, you know, forgo the pilot for that person.

Jennifer Montgomery: Got you. OK, thank you very much.

Dan Green: You're welcome.

Operator: Your next question comes from the line of Cathy Keefer.

Cathy Keefer: Yes. Thank you for taking my call. I'm calling from Waynesboro, Pennsylvania, Family Practice. We've been doing PQRIs for years as well; we use the claim based. I'm wondering here with the beginning of 2013, with the two transitional care management codes which are new for this year, will they be included in the patient encounters when we're reporting these three measures that we—our office does?

Molly MacHarris: Hi, this is Molly. I think what's probably going to be best to get you an answer to this question—and we apologize, we don't have a measure specification manual here in the room—is if we gather your contact information and our PMBR folks on the line, they will get back to you, if not later today, tomorrow.

So, if you can give me your contact info, we'll make sure someone gets back to you.

Cathy Keefer: OK, my number is 717-762-7110.

Molly MacHarris: And what's your name again, ma'am?

Cathy Keefer: Cathy Keefer. C-A-T-H-Y, K-E-E-F-E-R.

Molly MacHarris: OK, great. We will make sure someone gets back to you on this question.

Cathy Keefer: Thank you very much.

Molly: Thank you.

Cathy Keefer: Yes.

Operator: Your next question comes from the line of Nancy Wermers.

Nancy Wermers: Hi, this is Nancy Wermers. I'm calling from Dr. Robert Moss's office out in California. And I just wanted some clarification on the e-Prescribing Incentive Program for 2012. You mentioned in the slides the ways to participate but didn't mention doing it via claims, which I guess at this point would be too late, but that's how we did it this year. Was that also a method you could report?

Dan Green: This is Dan. Yes, you could, and you're exactly right. We didn't go over it because for claims submission at this point, you know, most folks aren't going to hold their claims for more than a week or two, and that's only if they have to, so …

Nancy Wermers: Right. I just wanted to be sure because I didn't see it there. Thank you.

Dan Green: Thank you.

Operator: Your next question comes from the line of Sharmeen Ahmed.

Sharmeen Ahmed: Hi. We went through EHR in October 1st, and I really wanted to do the—meet the Meaningful Use for the last quarter of the year. I was wondering if I could also get EHR incentive. And PQRS? We haven't done it before; is that also eligible for?

Dan Green: So, the Meaningful Use—as you mentioned, if you started in October you should have—be able to collect the 3 months.

You can participate in PQRS, but again, as we discussed in the slides, it would—you would need to participate using one of those methods. And those three methods were registry, as you'll recall, EHR Direct, and data submission vendor.

But if you only started using your EHR in October, it would be a little bit late for you to report via that method. However, you still could conceivably report using a registry. You could contact one of the registries on our list, and you'd have to get the information together for them, partly from your EHR but also partly from your paper record, or whatever records you were using before your implementation of EHR.

Sharmeen Ahmed: OK. And how about eRx? We used to do it by claim. Can we still do it, or I heard one of you guys say that probably that's not possible. We can only get Meaningful Use incentive, not the EHR?

Dan Green: Well, you can—a couple things here: You can't do claims at this point for 2012, because 2012—again, unless you've been holding your claims for the whole time, you know, which is not likely. So claims is too late to do, but you could report via registry.

You could report maybe if you have 25 e-prescribing events from your EHR, if your EHR is a PQRS/e-prescribing–qualified EHR. So you could report directly from them—from that if they are—if it is.

You cannot get a Meaningful Use EHR incentive payment for Medicare and a Medicare e-prescribing incentive. So those two programs in terms of earning an incentive are mutually exclusive.

However, by getting the Meaningful Use incentive it does not preclude you from getting an eRx payment adjustment. So it still would behoove you, if you're able to get the eRx data in, to get it in, because at least that would get you out of the 2014 payment adjustment.

Sharmeen Ahmed: And for the PQRS, can I still do just one measure for 2012 since we were not following up with it?

Molly MacHarris: Well, this is Molly. Just to clarify one other point: You can report via claims for the first 6 months in 2013. That's the last reporting period to avoid the 2014 payment adjustment. As Dr. Green mentioned earlier, there is the full year, calendar year 2012 reporting period, which is your first option to avoid the payment adjustment.

But your second option is by reporting 10 instances via claims from January 1st, 2013, through June 30th, 2013. And the only submission method for that is via claims. So, just wanted to clarify that.

Sharmeen Ahmed: OK.

Molly MacHarris: And then for your question related to PQRS, the PQRS payment adjustment reporting period does not begin until calendar year 2013. So for 2012 participation you should participate in one of our traditional methods, such as three measures at 50 percent or 80 percent, or a measure group.

Sharmeen Ahmed: OK. OK, thank you so much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Jeannie Curtis.

Jeannie Curtis: Hello.

Dan Green: Is that Jamie Lee Curtis?

Jeannie Curtis: Yes, close.

Dan Green: Oh, OK.

Jeannie Curtis: My question is about identifying whether a provider is eligible or not. We have a part-time nurse practitioner who only worked last year 20 hours per week, and I get confused about what she's actually eligible for doing.

Dan Green: So she could—this is Dan—she could report PQRS, and if she doesn't report PQRS through one of the methods that we outlined at the beginning of the talk today, she could potentially be subject to a payment adjustment in 2013 because there will be billable charges for her.

So, you know, we at Medicare won't necessarily go, "oh, well, this nurse practitioner is only working 20 hours." What we would see is, OK, this person doesn't see very many Medicare patients. It could be because they're working 20 hours; it could be because, you know, they do a lot of adolescent medicine. I mean, who knows what?

So we won't be able to distinguish between—you know, the reason behind that.

Jeannie Curtis: Would she—would it behoove me then to go after a hardship exemption if I—would she be exempt?

Dan Green: Well, you're talking about for eRx now, or you're talking about PQRS?

Jeannie Curtis: Either one.

Dan Green: OK, because, I mean, eRx, you could go for a hardship exemption, but PQRS there are no hardship exemptions at this point.

Jeannie Curtis: OK, all right, very good. Thank you very much; that was all I needed.

Dan Green: Thank you.

Jeannie Curtis: Bye.

Dan Green: Bye.

Operator: Your next question comes from the line of Dr. Modupe Aiyegbusi.

Modupe Aiyegbusi: I'm still just chiming in; our questions have already been answered, but we're just still listening.

Charlie Eleftheriou: OK, thank you.

Modupe Aiyegbusi: Thank you.

Operator: Your next question comes from the line of Mike Deyett.

Female: Hello?

Mike Deyett: Hi, this is Mike Deyett from ReportingMD. I believe that's what she was referencing.

I'm calling to ask just a couple of questions, one that came up—I have a question to a prior question, and also one that we've been trying to get results a little while through the QualityNet help desk.

The first question has to do with IACS accounts, on whether we can self-nominate, using our own IACS account, our GPRO clients?

Dan Green: We're conferring.

Charlie Eleftheriou: Give us one second, please.

Molly MacHarris: Hi, this is Molly. The group practices that you would be assisting with their submissions, they will have to self-nominate on their own behalf. So they will need to obtain their own IACS accounts to self-nominate for the January timeframe.

We do, again, have an additional timeframe in the—around the summer of this year where group practices can self-nominate/register as well, but they would need to have an IACS account.

Mike Deyett: So when we get to the point of doing submission, are we submitting under their IACS account or our own as a submitter—as a registry, DSV, and EHR Direct vendor?

Dan Green: You would be submitting under your own IACS account on their behalf.

Mike Deyett: On their behalf. But they will need—just to self-nominate, we'd need to have an SO, two-factor account, and then a PQRS submitter or an EHR Direct submitter to self-nominate under one of those three programs for reporting GPRO through a registry, DSV, EHR Direct?

Dan Green: Yes, that is the case as it stands now. We will look into it for future years, but this is the way it is for right now.

Mike Deyett: All right, thank you. And my second question had to do with a prior call. I think I heard you correctly, or perhaps not. This is another question we've been working on with the QualityNet help desk. My understanding from QualityNet that there is a hardship exemption applied to those who are doing the EHR Incentive Program under Meaningful Use and can avoid the penalty if they're in Meaningful Use—is that correct or incorrect?

Molly MacHarris: This is Molly. That is correct. We did finalize in the 2013 Physician Fee Schedule two additional hardship exemptions that are related to the Meaningful Use Program, and we finalized those for both the 2013 e-prescribing payment adjustment and the 2014 e-prescribing payment adjustment.

So as long—the two hardships are: One, they would have to achieve Meaningful Use during certain time periods, and the time periods were defined in the rule, and they are also available on our actual announcement. For the 2013 payment adjustment, they would have had to have achieved Meaningful Use from January 1st, 2011, through June 30th, 2012, and they would have had to have attested by the end of this month, January 31st.

And then the second hardship is that they need to demonstrate their intent to participate in the EHR Incentive Program and adoption of certified EHR technology by registering for the EHR Incentive Program by the end of this month—again, January 31st.

And the item to note on the second hardship is that the EHR Incentive Program participants must provide their entire EHR certification number in their registration and attestation module to receive this hardship.

Dan Green: Remember, though, this is for eRx.

Mike Deyett: That's correct. Yes, and that's how we've been communicating it exactly to our clients. But I just wanted to make sure because I think the answer to a prior question said that they—if they were doing Meaningful Use, in order to avoid the penalty they needed to do an e-prescribe submission if they're doing Meaningful Use to avoid the penalty, which they can qualify if they do exactly what I think Molly just referenced.

Dan Green: Yes, I think the question we were answering—or at least how we interpreted it, or how I interpreted it anyway—was Meaningful Use in lieu of PQRS, because there aren't any PQRS hardships...

Molly MacHarris: Right, and…

Mike Deyett: … two questions prior to that, but thank you. I appreciate it. Well done. I appreciate the feedback.

Molly MacHarris: And just one other note: The information that I mentioned, the announcements, those were provided prior to this call, and it's provided in that timeframe.

Mike Deyett: Yes, we did receive them.

Molly MacHarris: OK, great. Thank you.

Operator: Your next question comes from the line of Karen Furbush.

Female: Hello?

Karen Furbush: Sorry, it was on mute. My question is in regards to a complicated year in 2012. We had the EHR go live, we did—we are working on three of the PQRS measures, and we also were awarded an ACO in July.

I know there's some complications, and I'm trying to get this wrapped up so I understand which one trumps which from the payment standpoint, and my understanding is that the ACO will take over for the TINs that are a part of that, that might have been in a PQRS measure. Is that correct?

Molly MacHarris: So, this is Molly. Let me just make sure I'm understanding your situation. So in program year 2012, your providers participated in an ACO program, is that correct?

Karen Furbush: Yes. They started in July.

Molly MacHarris: OK. And how did they participate in PQRS prior to that?

Karen Furbush: My understanding—and that's what I'm trying to figure out internally. I know they've been—they created three of the measures, and they were dropping those through claims.

Molly MacHarris: OK. Give us just one moment.

Karen Furbush: OK.

Molly MacHarris: OK, so just a note on the ACO PQRS interaction: So for the ACO that your providers are participating under for that specific TIN, if they successfully complete the quality measures portion of the ACO Shared Savings Program, they will receive credit for PQRS as well.

The question you're asking about the three measures that were dropped or retired—I'm sorry, I'm not quite following that point or what the question is there.

Karen Furbush: I believe the question is, if they were—if they had that PQRS measure set up for three different items for the whole calendar year, and then we were awarded the ACO midyear, does the ACO take over in July for those measures or—I mean, the payment structure is a little confusing, how that will work?

Regina Chell: So I think you're talking about two different things. So, let me kind of just—this is Regina. So let me rephrase it to see if I'm understanding you correctly.

I think you're talking about a group who were reporting—or a TIN-NPI who was reporting for PQRS as an individual, reporting on three measures. Then somewhere in the calendar year that NPI as part of a TIN now is in an ACO. So the ACO then would be reporting for—through the group practice reporting option through the Web interface to meet the PQRS incentive requirements. Is that what you're saying? Or asking about?

Karen Furbush: Yes.

Regina Chell: OK. So, yes, the ACO nomination trumps the individual reporting. So we would only look at the reporting for the TIN-NPI combination under the ACO.

Karen Furbush: OK, great, thank you.

Regina Chell: Yes.

Operator: And your next question comes from the line of Leann Denissen.

Leann Denissen: Hi, this is Leann Denissen from Baycare Clinic in Green Bay, Wisconsin. And I just wanted to expand on a previous caller's question on the administrative claims option and self-nominating.

We've been reporting since 2007 as individual providers. We are a group that kind of flirts with that 100 EP volume, so we did experiment with possibly doing registry as a GPRO this year, but we decided to just continue on as we are, as individual EPs.

So I'm understanding that we can continue to report individually and then later this year self-nominate, so that we—as administrative claims—so that we can avoid the VBM and the 2015 penalty and potentially get a bonus. But my question is specifically about the types of measures that come along with that. Are we still able to report our choice of measures, or are we bound by that 14 preventative and chronic care measures requirement? Does that make sense?

Dan Green: Yes. No, you're free to report whatever measures you want to report. So again, electing administrative claims—obviously there are certain—you know, those measures have been selected, if you will.

So that's what we would be looking at, but to avoid the payment adjustment for VBM, Value-Based Modifier, as well as PQRS. But to earn the incentive, you know, Dr. Jones could report, you know, the diabetes measures, Dr. Smith might report three preventive care measures, and one other doctor may report a measures group, for example—whatever you want.

Leann Denissen: Yes, because, see, the issue is they're all specialty physicians. They're surgeons, and they don't do preventative and chronic care. So those measures are…

Dan Green: That was just an example.

Leann Denissen: OK.

Dan Green: You could do a perioperative measures group, you know, whatever.

Leann Denissen: OK.

Dan Green: Any measure.

Leann Denissen: OK. And that doesn't matter if we decide to quality tier or not? Do we still have that option? To quality tier under the VBM?

Molly MacHarris: Well, the quality tiering—you're correct, that applies specifically for the Value-Based Payment Modifier, and I do believe under the administrative claims selection you can still elect quality tiering. And what happens when you make that selection is they will look at your provider's performance on the administrative claims measure. So that would be the option that you had selected.

If you selected registries, they would look at your performance based on the registry measures that were reported.

Leann Denissen: So you're saying when they look at the administrative claims measures, you're talking those preventative care measures?

Molly MacHarris: It would be the entire set of administrative claims measures that were finalized in the rule.

Leann Denissen: And I think that's only those—I think they're all preventative care related.

Molly MacHarris: I believe …

Leann Denissen: So if that doesn't apply to us, they won't have anything to look at? What would they assess, then?

Dan Green: They're not going to go, "Oh, well, you know, this doctor is a"—I'm making this up now—they're not going to say, "This doctor is a radiologist, this doctor is a pathologist." They're going to say, "This doctor elected administrative claims; that's what we're going to look against."

So if the measure is a mammography measure, and they can't tie that particular doctor to the mammogram in any way, then that doctor is not going to get credit for that particular measure. And while you'll still get out of the payment adjustment for both VBM and PQRS, I would think that you would not want to elect quality tiering, because it's not going to look like you're doing the best quality actions for your patients, even though—you know, because it's not in your purview.

Leann Denissen: OK.

Molly MacHarris: But we do—I do just want to suggest that you actually reach out to the Value—we're specific to the PQRS program and the e-prescribing program, and we work very closely with the Value-Based Payment Modifier staff here within CMS, but if you have any specific questions related to the implementation of the Value-Based Payment Modifier, we do suggest that you contact them.

And their Web site is actually on the last page of the list of announcements here. And they can explain to you in more depth. I believe they have an e-mail box where you can send questions, and they are monitored by CMS staff.

Leann Denissen: And that is different than the QualityNet help desk, then?

Molly MacHarris: It is different from the QualityNet help desk, and I apologize, I don't have the information in front of me, but it is on the last page of the announcements that were sent out previously.

Leann Denissen: OK, I'll follow up with them. Thank you.

Molly MacHarris: Thank you.

Charlie Eleftheriou: OK. And we've only got a minute or two left, but we will try to take one more call if we could make it quick.

Operator: Your final question, then, comes from the line of Laurie Kaiser.

Laurie Kaiser: Hi. Thanks for taking my call. I am a mental health biller. I'm billing for individual private practice providers. This is totally new to me. Some of my providers have asked me to investigate submitting via the claims method, and I'd like instructions on how to do that.

Dan Green: That's a great question. We do have resources on our Web site—basically, getting started with reporting for PQRS, but additionally, our QualityNet help desk is set up to introduce you to PQRS and kind of walk you through the process.

So that would be, honestly, where I would go to start off with, either there or on our Web site for the resources. There's some pretty specific information that really breaks it down in terms of where you place certain codes, etcetera. There's examples of claim forms and things of that nature in the—on the Web site.

But either the QualityNet help desk or our Web site.

Additional Information

Charlie Eleftheriou: And those links are available on slides 28 and 29 of today's presentation.

And unfortunately, that's all the time we have for today. If we didn't get to your question, contact the quality support help desk, using the information on slide 29, from 7:00 a.m. to 7:00 p.m. Central, Monday through Friday, or e-mail qnetsupport@sdps.org. Again, additional content is available—I'm sorry, resources—available on slides 28 and 29.

Please note that while we are not going to be able to address every question, we'll try to review them all and help—and develop Frequently Asked Questions and educational products and inform future calls and presentations.

On the last slide of today's presentation you'll find the evaluation slide with a URL to link you to evaluate today's presentation. Please do so. Evaluations are anonymous and confidential.

I should also point out that all registrants will receive a reminder e-mail from the CMS National Provider Calls resource box within a couple of business days regarding the opportunity to evaluate this call. We do appreciate the feedback.

I'd like to thank everyone who participated today. An audio recording and written transcript will be posted to the National Provider Calls Web page on the CMS Web site within approximately three weeks.

Have a great day, everyone, and we'll speak to you next time.

Operator: Thank you for dialing in for today's conference call. You may now disconnect. Speakers, please hold the line.

-END-