Centers for Medicare & Medicaid Services
Physician Quality Reporting System
and Electronic Prescribing Electronic Incentive Program
National Provider Call
Moderator: Geanelle Herring
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Contents

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Operator: At this time I would like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing National Provider Call on Claims Report – Base Reporting conference.

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.

Thank you for your participation in today's call. I will now turn the call over to Geanelle Herring. Geanelle, you may begin.

Geanelle Herring: Thank you, Holley. Hello everyone and welcome to the 2012 Physician Quality Reporting System and Electronic Prescribing Electronic Incentive Program National Provider Call. My name is Geanelle Griffith Herring and I will serve as your moderator today.

Following a few programs announcements and a presentation that will provide an overview of claims-based reporting for both the Physician Quality Reporting System and the Electronic Prescribing Incentive program, the phone lines will be open to allow you to ask question of CMS subject matter experts gathered here today.

With me are those subject matter experts who have been instrumental in the development of the policies and procedures and measures and certification guidelines and all other aspect of those programs. I will now turn the call over to Dr. Dan Green. Dr. Green?

Introduction

Daniel Green: Thank you, Geanelle. Welcome everybody. We're glad you could dial in to today's call. We hope you'll find it informative and valuable use of your time. We appreciate your continued interest in the Physician Quality Reporting System and the Electronic Prescribing Incentive program.

Today, we're going to talk about claims-based reporting as that still is the most popular way for folks to submit. And we're going to also talk about how

to implement the 2012 client's base reporting of measures which will hopefully help facilitate the reporting of the quality data by those eligible professionals who want to participate in a Physician Quality Reporting System program or the eRx Incentive Program.

In order to make sure that folks have plenty of time for questions, I'm going to limit my remarks and turn the meeting to Diane Stern for some announcements. We'll then proceed to the presentation, again, thank you for your time and attention today.

Announcements

Diane Stern: Thank you, Dr. Green. Good afternoon to everyone. Prior to making announcements, I would like to make sure that everybody can access the PowerPoint presentation so they can follow this call. So if you go to the PQRS Web site at http://www.cms.gov/pqrs and if you look on the lefthand side, there are some section pages and the fourth section page is CMS-sponsored call page. If you click that page on and scroll down to the download section, you will find a presentation under February 21st, 2012, National Provider Call presentation.

OK. To go on with announcements, the first announcement will be on EHR submission. CMS will like to remind all eligible professionals that the PQRS portal for program your 2011 EHR submission is now open. Eligible professionals have until March 31st, 2012 to submit their EHR data.

All eligible professionals submitting EHR data will need to obtain an IACS account. Additional information related to obtaining the IACS account can be viewed on the quick reference guide, which is located on the home page of the PQRS portal. That link address is https://www.qualitynet.org//portal/server.pt.

The next announcement will be on error with – on error with measure number 235. CMS has recently identified an error related to the submission of measure 235, hypertension plan of care for the 2012 Physician Quality

Reporting System. Hypertension plan of care is a claims registry measure with G-codes that are inactive due to an error found on a HCPCS page.

Consequently, this has resulted in claims containing the G-code associated with the measure being rejected by the Carrier MACs or denied. The G-code, G8675, 8676, 8677, 8678, 8679, and 8680 will be reactivated with the next update on the HCPCS page in April 2012.

In the interim, eligible professionals who have intended to report this measure via claim for the 2012 PQRS may want to consider taking the following steps. For 2012 claims-based reporting, PQRS requires at least three measures to each be reported at the – at 50 percent reporting rates. Eligible professionals may want to consider reporting additional measures to substitute for now – for measure number 235 hypertension plan of care.

Hypertension plan of care is a current visit measure which requires reporting of 50 percent of eligible patient visits. Therefore, eligible professionals could report the measure of more than 50 percent or eligible – of eligible visits from April to December 2012 to increase the likelihood for successful reporting of the measure.

The next announcement will be on direct mailing – direct mailing notification. An important direct mailing is being sent out to inform eligible professionals who are subject to a payment adjustment under the Medicare Electronic Prescribing Incentive program because they did not meet the reporting requirements for the six-month reporting period of January 1st, 2011 to June 30 of 2011. This mailing began on January 27th and will be completed by January – I mean by February 27th, 2012.

This mailing did not take into account whether its significant hardship exception request was submitted or not. Eligible professionals who submitted a significant hardship exception request for the 2012 payment adjustment may still receive this mailing. CMS will separately notify eligible professionals who submitted a significant hardship exemption request whether the request was approved or denied via e-mail.

The next announcement will be on avoiding the 2013 payment adjustment. We would like to remind eligible professionals if you do not successfully ePrescribe for 2011 that you still have an opportunity to avoid the 2013 ePrescribing payment adjustment by reporting 10 electronic prescribing events during January 1st, 2012 through June 30 of 2012.

For more information about avoiding the 2013 and the 2014 ePrescribing payment adjustment, you can go to the ePrescribing Incentive Program Web site at http://www.cms.gov/erxincentive. And click on the educational resource link then scroll to the download section to view the fact sheet titled, "2012 E-prescribing Incentive Program Future Payment Adjustments."

The next announcement will be on 2013 ePrescribing hardship exemption. CMS has completed our review for all hardship exemptions submitted on 2012 payment adjustment. CMS will be re-opening the communication support page on March 1st, 2012 for individual eligible professionals and selected ePrescribing group practices to request their significant hardship exemptions for the 2013 ePrescribing payment adjustment. Individual eligible professionals and selected ePrescribing group practices will have through June 30th, 2012 to request their significant hardship.

We would like to advise eligible professionals to check the CMS Web site spotlight page for recent updates when physicians file reporting ePrescribing Incentive Program and almost 2012 eligible – I mean I'm sorry, a number of 2012 educational products have been posted there.

And I will now turn the announcements over to Dr. Dan Green.

Promotion

Daniel Green: Thank you, Diane. Actually, before we go on with the announcements, I just want to pause for a second and thank Geanelle Griffith, Diane Stern, and Lauren Fuentes, especially, for putting this call together on a monthly basis. And hopefully as I mentioned, you'll find this informative and will make the reporting of the Physician Quality Reporting easier.

We don't usually do this either but we're going to have a brief advertisement for next month's National Provider Call. Next month, we're going to be talking about the Million Hearts initiative and it's an HHS-wide initiative that we feel is very important.

Basically it's – I'm sure many of the folks that are dialed in today realize, heart disease and stroke are respectively, the first and fourth leading causes of death in the United States. Cardiovascular disease alone is responsible for one out of every three deaths in the U.S. and it cost the nation more than $440 billion every year in healthcare expenses and lost economic productivity.

To reduce the burden, the Department of Health and Human Services, Centers for Disease and Control Prevention, Centers for Medicare and Medicaid Services and broad range of public and private sector partners have launched the Million Hearts initiatives to enhance cardio disease, I'm sorry, cardiovascular disease prevention activities a proven, effective and inexpensive clinical and community interventions.

To provide you more detailed information about our Million Hearts, CMS has decided to make this topic the subject of our month – March National Provider Call. And I just want to briefly mention, many of you know in PQRS already, we have the cardiovascular measures group which are many of the measures in the Million Hearts campaign.

In fact, in our EHR reporting program, we have all the measures in the Million Hearts campaign which includes the first HER-only collectible measure having to do with cholesterol both assessing cholesterol level as well as assessing control based on risk factors. It's a risk stratified measure and again it's only collectible by EHR at that point, particular measure.

But we would encourage folks that are contemplating beginning reporting in PQRS to review the Million Hearts measures and if they apply to your practice, we encourage you all to consider reporting on these measures. Again, it's not mandatory but we'll be discussing more in the March call for this important topic.

So, thanks for letting me make that announcement. Diane, I'm now going to turn the call over to Lauren Fuentes.

Lauren Fuentes: Thanks, Dr. Green. Our last announcement for today is regarding the Physician Compare Web site. On January 26, 2012, CMS released its quarterly enhancement of the Physician Compare Web site. Improvement in this release reflects recommendations made during July 2011, usability testing as well as responses to concerns raised by users and stakeholders.

The release includes updates to the user interface of the home, result and profile pages to make the search experience more intuitive and responsive to user needs. The Web page content has also been reorganized to make it easier for users to find information they are seeking. For example, that is a new menu option; provider resources, which is direct and easy to find links for providers to find information regarding in updating their PECOS information.

The release also improves a feedback tool, so users may contact Physician Compare administrators directly with questions and concerns. This release is part of CMS's continued efforts to improved Physician Compare both in terms of data accuracy and usability. CMS will continue to provide periodic updates regarding new releases and updates to the Physician Compare Web site.

That concludes our announcements for today, just a quick reminder that next month's call is scheduled for March 20th, 1:30 to 3:00 p.m. Eastern Standard Time.

Presentation

Kimberly Schwartz: OK, we're going to begin with the presentation on slide three. In terms of the presentation's agenda, we're going to go over the claims-based reporting, the process encoding, how to report using the CMS-1500 claims form, helpful hints, resources, and we'll complete the call with obviously a question and answer session.

We're going to begin on slide five, the advantages of the claim-based reporting. Benefits include readily accessible to all eligible professionals as

with the part of routine billing process. There's no need to contact the registry or EHR for submission of the data. Simple to collect measures and begin reporting, you add obviously the respective quality data code, the QDC, to the claim. Possible downside would include limitation base on billing and eligible professional's burden.

Next slide, six. Claims-based reporting of the quality of the data. Medicare providers submit claims via CMS-1500 for reimbursement for billable services rendered to part B beneficiaries.

Eligible professionals use their individual National Provider Identifier, also known as NPI, to submit for services on Medicare Part B beneficiaries.

Claims follow a process so the information gets to the CMS National Claims History file or NCH.

Standardized codes are found within each Physician Quality Reporting measure specification and within the eRx measure specification.

These standardized codes are used to identify clinical services, diagnosis, and surgeries or procedures which are found in the denominator and are found within each Physician Quality Reporting measures specification and within ePrescribing measures specification. Those include CPT, ICD-9-CM, or the HCPCS codes or ICD-10 codes in the future.

Slide seven is giving you an overview of the Physician Quality Reporting and ePrescribing claim-based process. In terms of the slide, the claims-based reporting process is represented by this diagram. Steps beginning from patient visit, to receipt of information into the National Claims History file are standard claims processing activity.

Let's walk through the slide. First, an eligible professional documents fulfillment of the measure's requirement and the medical record.

Next, the quality data code or QDCs also known as possibly a CPT-2 code and/or G-code may be entered onto an encounter form. When an eligible professional bills for service included in the measure's denominator coding, codes associated with the measure are captured as part of the claims submission process. Then the QDCs are submitted to the Carrier or the A/B Medicare administrative contractors, also known as the MACs, either by electronic submission or through paper-based submission of the claim.

Claims data are submitted to the Medicare claims processing contractor and sent to the National Claims History file. The Physician Quality Reporting and ePrescribing QDC line items will be denied for payment but are tracked and then passed through claims processing system for analysis. The remittance advice, the RA, explanation of benefit, denial code, and 365 is your indication the Physician Quality Reporting codes were received into the National Claims History.

Finally, following the close of the previous programs year reporting period, CMS will analyze all of the claims in the NCH file to determine incentive eligibility. For Physician Quality Reporting, incentive eligibility will be determined based on whether an eligible professional meets the relevant criteria for satisfactory reporting of Physician Quality Reporting measure data for that particular program year.

For ePrescribing Incentive Program, incentive eligibility will be determined based on whether the eligible professional meets the relevant criteria for being a successful electronic prescriber for that particular program year.

Following this analysis, confidential feedback report as well as earned incentive payments if eligible are then produced and distributed to participants. These typically occur mid-year following the close of the previous program year's reporting period.

Slide eight. What do these codes mean? Understanding the measures specification construct, you have your numerator which entails CPT-2 and for

your G-code describe the clinical action required for performance over the denominator which is your ICD-9, also the future ICD-10, and your CPT Category I code. This is the eligible cases for the eligible patient population. Each measure has detailed classification consisting of a reporting numerator and a reporting denominator. The reporting numerator includes, as stated, the CPT Category II code and/or G-code which includes a specific clinical action. Physician quality reporting also uses the 8P reporting modifier to identify action not performed or reason not otherwise specified.

Eligible professionals should use the 8P reporting modifier sensitively for applicable measures they had selected to report. The 8P modifier may not be used freely in an attempt to meet satisfactory reporting criteria without regards toward meeting the practices quality improvement goal.

The reporting denominator indicating eligible cases includes patient's demographics, diagnosis code with exception, and encounter code which should be your CPT or your HCPCS codes.

Slide nine. Reporting frequency. Physician quality reporting, you report one time for patient for NPI, TIN combo per reporting period at the patient level. Report once for every procedure performed, report for each acute episode, and/or report for each visit.

For ePrescribing, we have a 12-month which is to earn the 2012 incentive payment and avoid the 2014 ePrescribing adjustment and report the required number of denominator-eligible visits. Six months to avoid the 2013 payment adjustment. Report on each billable Medicare Part B service, claims-based reporting is the only option for the six months ePrescribing reporting period.

Specified in the respective documentation regarding on this slide, each Physician Quality Reporting measure has a reporting frequency requirement or a tag each eligible patient fee during a reporting period for each eligible professional or NPI. So the 12-month ePrescribing period, the measure monthly reported for each denominator-eligible visit.

For the six months ePrescribing period, to avoid the 2013 payment adjustment, the ePrescribing G-code can be recorded on any Medicare Part B claim that includes a billable Part B service regardless of whether the service contains coding in the ePrescribing measure denominator.

Slide10. How to start reporting. There is no registration required, simply start reporting the QDCs listed in the measures you have selected on applicable Medicare Part B claims. Below are some helpful tips to aid you in the reporting process.

Report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a missed reporting opportunity that can impact incentive eligibility.

Avoid including multiple dates of service and/or multiple rendering providers on the same claim. This will help eliminate diagnosis codes associated with other services being attributed to another provider's services.

For measures that require more than one QDC, please ensure that all codes are captured on the claim.

Slide 11. Sample CMS-1500 form. On slide 12, you're going to see the example of a sample CMS-1500 form and we're going to walk through this claim relevant to the ICD-9 CMS diagnosis are entered in field 21. Up to eight diagnoses may be entered electronically or up to four diagnoses may be included on papers.

The numbers one through six by each line identify the claim line item. Only one diagnosis can be linked to each line item whether billing on paper or electronically. All based claim diagnoses and valid QDCs reported are considered to be analysis of reporting and applied to all rendering providers on the claim reporting the measure.

Slide 13, a continuation of the 1500 claim form. In 24D includes procedures, services or supplies entered to the service code including CPT, HCPCS, CPT

Category II, and/or G-codes with any associated modifiers and are indicated in the measure certification.
Be sure to include a single reference number in the diagnosis pointer field 24E, it corresponds with diagnosis pointer number in field 21.

For CPT Category II codes and/or G-codes which supply the numerator for QDC reported on the same claim the denominator billing code for the same beneficiary, for the same date of service, and by the same eligible professional or individual NPI to perform the coverage service as the payment codes. Usually ICD-9, CPT Category I, or HCPCS code which supply the denominator.

For Physician Quality Reporting measures requiring submission of more than one QDC, report each QDC in a separate line item. Referencing one diagnosis and including the rendering provider NPI. Regardless of the reference number and the diagnosis pointer field, all primary and all secondary diagnoses are considered in Physician Quality Reporting and ePrescribing analysis.

Eligible professionals should review all diagnosis and encounter codes listed on the claim to ensure they're capturing all reported measures applicable to that patient's encounter.

Slide 14, continuation again of the CMS-1500 form. QDCs must be submitted with a line item charge of zero or a penny. The beneficiary is not liable for this nominal amount. If your billing software limits claim line item, add a nominal amount to one of the QDC line items on the second claim. The charge field can not be blank.

Physician quality reporting and ePrescribing analysis will subsequently join those claims based on the same beneficiary, for the same date of service, for the same TIN-NPI and analyze them as one claim. The QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in analysis.

Eligible professionals may submit multiple codes on more than one measure on a single claim as long as the corresponding denominator codes are also line items from that claim.

Slide 15. For the group billings, the rendering NPI of the individual eligible professional who performed the service will be used for each line item in Physician Quality Reporting and the ePrescribing calculations. This NPI should be entered in field 24J. The Tax Identification Number, otherwise known as the TIN of the employer, is entered in field 25. The NPI of the billing provider is entered in field 33A. Submit for solo practitioner or group billing appropriately.

In slide 16, for claims-based reporting of the electronic prescribing measure, the same basic principal applies. There is only one QDC for ePrescribing G8553 which indicates at least one prescription created during the encounter which generated and transmitted electronically using a qualified ePrescribing system.

Please note for purposes of reporting the ePrescribing G-code, to avoid the 2013 ePrescribing payment adjustment which is for the six-month reporting period, the ePrescribing G-code can be reported in any billable Medicare Part B service furnished during the reporting period, regardless of whether the code for such service appears in the denominator.

Slide 17 is going to begin to discuss some helpful hints on 18. If all billable services on the claim are denied for payment by the Carrier or A/B MAC, the QDCs will not be included in Physician Quality Reporting analysis.

If the denied claim is subsequently corrected and paid through an adjustment, reopening, or the appeals process by the Carrier or A/B MAC, with accurate codes that also correspond to the measure's denominator, then any applicable QDCs that correspond to the numerator should also be included on the corrected claim.

All claims adjustments, re-openings, or appeals processed by the Carrier or

A/B MAC must reach the national Medicare claims system data warehouse or the National Claims History file on February 22, 2013 to be included in analysis. Claims may not be resubmitted only to add or correct QDCs. Claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the Carrier or A/B MAC.

Slide 19, helpful hints continued. The Remittance Advice; explanation of benefits, denial code, N365 is your indication that the Physician Quality Reporting and/or ePrescribing codes were received into the National Claims History. N365 reads, "This procedure code is not payable. It is for reporting, information purposes only."

The N365 denial code is just an indicator that the QDC codes were received, it does not guarantee the QDC was correct or that incentive quotas were met. When a QDC is reported satisfactorily by the individual eligible provider, the N365 can indicate that the claim will be used for calculating incentive eligibility.

Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the Carrier or A/B MAC. Each QDC line item will be listed with the N365 denial remark code. If no remark code is present, please follow up with your Carrier or A/B MAC or billing software vendor or clearinghouse.

Slide 20 is satisfactory reporting, please review all denominator codes affecting claims-based reporting, particularly those measures that do not have an associated diagnosis. For example, 110 influenza immunization, number 154 falls risk assessment, 47 advance care plan or 125 adoption, use of electronic prescribing.

You will need to report on each eligible claim as instructed in the measure specifications. Please review all diagnoses if applicable and CPT service encounter codes for denominator inclusion in Physician Quality Reporting and ePrescribing, the claims that are obviously denominator eligible.

All denominator-eligible claims must have the appropriate QDCs or QDC with the allowable CPT-2 modifier along with the individual eligible professional's NPI. Use the measure specifications for the current program year and report as instructed for Physician Quality Reporting and ePrescribing.

We'll move on to slide 22 which is for resources. The CMS Physician Quality Reporting and ePrescribing Incentive Program Web sites are official sources for all program materials which we strongly encourage that you utilize. The educational resources can be found on the below cited pages. The CMS Physician Quality Reporting and ePrescribing Incentive Program Web sites are the ones also listed with all our program materials.

Also you can notify the QualityNet Help Desk is 866-288-8912 and they're open Central Standard Time, Monday through Friday from 7 a.m. to 7 p.m., you will be asked to provide basic information such as your name, practice, address, phone number, and e-mail.

So, QualityNet Help Desk can also help you with your program, questions ranging from how do I get started to accessing you feedback report for detailed measure of inquiry.

Just some key points to remember in concluding the presentation, please use the current Physician Quality Reporting and ePrescribing Incentive Program information available on the CMS Web site. Review the respective detailed measure specification to determine the appropriate codes to place on the eligible claim.

QDCs must be submitted on the same claim as the billing code for the same beneficiary, for the same date of service, by the same eligible professional who performed the Part B-covered service provided under the PFS.

Claims may not be resubmitted solely to add QDCs. And please check your RA for the N365 code to confirm receipt of QDCs into the National Claims History.

Thank you and that completes our presentation.

Question and Answer Session

Geanelle Herring: Thank you, Ms. Kim Schwartz. At this time we will pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the numbers of participants on the line with us today.

Please note that there will be a moment of silence while we tabulate the result. Holley, we're ready to begin keypad polling.

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. Today, we would like 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.

At this time please use your telephone keypad and answer the number of participants that are currently listening in. If you are the only person in the room, enter one. If there between two and eight of you listening, enter the corresponding number between two and eight. If there are nine or more of you in the room enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Once again, please continue to hold while we continue the polling.

Geanelle Herring: We will open the line for Q&A session shortly. But before we begin I'd like to remind everyone that this call is being recorded and transcribed. So please, state your name and the organization in which you represent.

In an effort to get as many as your questions asked as possible, we ask that you limit the number of questions to just one.

Operator: Thank you for your participation. We will now move into Q&A session for this call. To ask a question press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and/organization prior to asking a question and pick up your handset before asking your question to assure clarity.

Please note that your line will remain open during the time you are asking your questions, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Kim Fransen.

Kim Fransen: Hi. This is Kim Fransen, and I'm calling from Winthrop Clinical Practice Billing. I had a question regarding the ePrescribe, we had submitted a hardship previously, we had six doctors, we submitted the identical hardship for each provider and four of the providers were approved and the rest were denied. They all have the same situation and the same scenario, I'm not quite sure why that is, so half of our providers are getting the 1 percent disincentive and the other half have not received it.

Daniel Green: So, the folks that are getting the payment adjustment, did you enter their individual NPIs as opposed to the group NPIs for those folks?

Kim Fransen: Yes, everything was entered identically for all them. Each provider was entered individually, each provider had the identical reasons, it was – everything was exact. So, I have no idea why half of them were approved and half of them were not.

Elia Cossis: Well I think – this is Elia Cossis, we're probably going to need a little bit of information to look into that. Could I get your name one more time and telephone number or e-mail and we'll follow up with you within the day.

Kim Fransen: OK. My name again is Kim Fransen.

Elia Cossis: Kim Fransen. OK.

Kim Fransen: And the e-mail is kfransen, F-R-A-N-S-E-N, @winthrop, W-I-N-T-H-R-O-P, .org.

Elia Cossis: OK, Kim, let me just – sounds good, kfransen@wintherop.org.

Kim Fransen: W-I-N-T-H-R-O-P.org. Winthrop.

Elia Cossis: We got it. OK. OK, Kim we will follow with you within, either today or tomorrow to see what's going on.

Kim Fransen: OK. Great. Thank you.

Elia Cossis: Thank you.

Operator: Your next question comes from the line of Debra Farley.

Debra Farley: Yes, Debra Farley with BILLPro Management System. We have a provider who is receiving a 1 percent payment adjustment but he was also granted significant hardship exemption. Does he have to call the quality help desk or would those claims automatically be reprocessed at some point?

Daniel Green: So he was granted the hardship exemption based on, how do you know that?

Debra Farley: Well, we're a billing company and he said – they said they have a letter. I don't know exactly how they qualify but they were on the phone with the help desk and the help desk did say, you know, they got the 1 percent, if you want to say disincentive but it didn't include the hardship exemption that they were granted.

So, I'm just trying to find out a little information if, you know, if there were any errors or whatever on timing as far as claims being processed with the reduction. And maybe there's a backlog in the hardship exemption processing.

Aucha Prachanronarong: So did the provider get an – received an e-mail indicating that their hardship exemption was granted?

Debra Farley: They say yes.

Aucha Prachanronarong: OK.

Debra Farley: I don't have a copy of that.

Aucha Prachanronarong: Yes. Because in general there is a lag between the times when the hardship exemption request is approved and when the claims – when the payment adjustment is stopped and the claims are reprocessed but I guess the first step is to confirm that he did receive an e-mail notification indicating that his hardship exemption is approved.

Debra Farley: OK. And then once he received that then he can call the help desk and say when will the claim start to be processed correctly or reprocessed?

Daniel Green: We're discussing it, so we'll be just a second here.

Debra Farley: That's all right. Thank you.

Aucha Prachanronarong: OK. So the help desk will be able to confirm, sorry not everybody in the room has a mic, so . . . .

Debra Farley: That's all right.

Aucha Prachanronarong: So the help desk will be able to confirm when – whether when or whether or not the hardship exemption was approved and whether or not the provider is still getting the 1 percent payment reduction but they won't be able to confirm when the claims will be reprocessed.

Debra Farley: So, when do you – at what point can we contact someone to see when they will be reprocessed? It would be like a month?

Aucha Prachanronarong: It will be 45 days when their claims are no longer being . . . .

Aucha Prachanronarong: So, once the help desk is able to confirm that they're no longer subject to the payment adjustment that it may take up to 45 days for the claims to be reprocessed.

Debra Farley: Thank you very much.

Operator: Your next question comes from the line of Linda Kaspar.

Linda Kaspar: Hello, Linda Kaspar with South Texas Medical Clinics. And my question relates to the measure 235, I heard the initial information about it earlier but there was a code, it was in the measure that wasn't addressed that's a 407 OF which we're also receiving rejections on, it's no longer a valid code. And could you again tell us what our options are for filing these after the April correction?

Kim Schwartz: In terms of the measure 235?

Linda Kaspar: Yes.

Kim Schwartz: So, once the codes, the G-codes those specific six G-codes that were listed at the beginning of this presentation are going to be activated as of April 1st, you will be able to successfully then report and submit on that measure.

We strongly encourage for – because it is a claims-based measure and you have to have 50 percent of your Medicare Part B population that you over report on that measure in those months to ensure that you have successfully been reported on that.

Linda Kaspar: Will you be counting those encounters that would qualify between January the 1st and March the 31st since we're unable to report the correct G reporting codes?

Kim Schwartz: No. Unfortunately no, we're not able to do that just because it is attached directly to that particular measure with that associated G-code.

Linda Kaspar: So you cannot edit out the dates of services that we're unable to file that will count against the doctor in his patient population?

Daniel Green: Give us one second.

Kim Schwartz: Right. So that's why we're strongly encouraging that you basically over report on this measure between the months of April through December 31st, 2012.

Linda Kaspar: All right.

Kim Schwartz: To compensate and take into consideration obviously for those providers that have already submitted their claim with this measure and this G-code attached to it.

Daniel Green: Other options would be to select another measure and/or report a measures group to avoid this particular measure.

Linda Kaspar: All right. What about the 405 OF code that was in the body of the measure that was not addressed in the G-code. Is that corrected as well as of April the 1st?

Aucha Prachanronarong: So, claims containing those codes are also being rejected or not but it is also being rejected?

Linda Kaspar: The 405 OF is part of that measure and it's also being rejected.

Aucha Prachanronarong: We'll have to look into that.

Linda Kaspar: All right. Thank you.

Daniel Green: Thank you.

Aucha Prachanronarong: Thank you very much.

Operator: Your next question comes from the line of Therese Blalock.

Therese Blalock: Hi. My question has to do with the 2013 measure certifications. Can you hear me?

Daniel Green: 2013 you said?

Therese Blalock: Right. We're not currently reporting when you plan to begin 1/1/2013.

Daniel Green: OK.

Therese Blalock: So there's no way, I guess what I'm asking, we would need the 2013 measurement specifications but there's also no way we can report in 2012 just to iron out any problems is there? I mean you have to start …

Daniel Green: A couple of things you could do, first of all how are you planning to report for 2013?

Therese Blalock: Claims based.

Daniel Green: OK. So what you could do is you could send in, you know, on a few patients some – the appropriate quality data code kind of as a test in 2012 even of your – even if your docs are not striving for turn and incentive in 2012.

Therese Blalock: Yes.

Daniel Green: So, you know, take a hint, take maybe one or two measures or maybe three measures of – and, you know, for five patients or whatever report in that quality data code, you should get an N365 back on your remittance advice, which will tell you that those codes made it into our National Claims History files and that way you'll get a sense that you're reporting, you know, the truth … .

Therese Blalock: Right. But then we wouldn't meet the threshold for 2012. Is there a disincentive that applies to us?

Daniel Green: No. There's no penalty for being unsuccessful other than you don't earn the incentive.

Therese Blalock: OK. But as of …

Daniel Green: But you still would get a feedback report for that matter.

Therese Blalock: Right. And so – but as of 2013 if you don't successfully report up to the threshold requirement you would see a drop in your fee schedule in 2015, correct?

Daniel Green: Yes. But the threshold and what have you for the disincentive if you will have yet to be determined. There'll be more information coming out in our proposed ruling …

Therese Blalock: OK. So I have no penalty to – I mean won't incur penalty by submitting some test data in 2012?

Daniel Green: I'm sorry, say that one more time?

Therese Blalock: We won't incur a penalty if we submit a minimum amount of test data in 2012?

Daniel Green: No. And you're talking about PQRS, I'm sure; as opposed to eRx, correct?

Therese Blalock: Precisely, yes. We're a physical therapy practice, yes.

Daniel Green: Great. OK. No, you will not incur a penalty so feel free to test both early and often.

Therese Blalock: Awesome. OK. Thank you.

Daniel Green: Thank you.

Therese Blalock: Bye.

Daniel Green: Bye.

Operator: Your next question comes from the line of Karrie Chubb.

Karrie Chubb: Yes, hello. My name is Karrie Chubb and I'm calling from the University of Spine Institute. And my question is concerning the ePrescribing – prescriptions, we have several prescriptions that are by law in California, we are not allowed to eScribe, oxycodone being one of them. How can we capture this? Do we still eScribe them and send the patient with a hard copy or are we not able to incur those patients into our eScribing data?

Daniel Green: So typically those patients would not be included into your ePrescribing data because most jurisdictions preclude – local jurisdiction anyway precludes

narcotics from being electronically prescribed. Maybe different in your area it – because it varies geographically, nationally it's permitted providing you have the proper prescribing software. But again, many local jurisdictions do prevent that from recurring.

So those patients would not be able to be counted if California does not permit it.

Karrie Chubb: So if …

Daniel Green: But things like muscle relaxers if permitted by your – by California not non-steroidal anti-inflammatory drugs, steroid such as prednisone if you're doing a medrol dose pack for back pain and things like that would be.

Karrie Chubb: OK. So, once we've started with the ePrescribing and we have found that it really our practice doesn't fit the requirements, can we opt out at a later time without penalty?

Daniel Green: No. Because the program itself is not an optional – I mean it's optional from the standpoint of you don't have to report it but if you don't report it – if you don't report in and you don't have a hardship that applies, you will be subject to the payment adjustment.

So, I mean yes, you don't have to report but you're, you know, you'll get a reduction in your Medicare payments.

Karrie Chubb: OK. So we're still in the catch-22 that if we have mid-management we can include those in the eScribing and we've – we have to find other patients that we can scribe to.

Daniel Green: Look again, if California permits you – if you have a system that allows – that you can ePrescribe narcotics like California allows you to do that, you can count them as successful electronic prescribing events.

The issue is many jurisdictions don't allow, local that is, don't allow ePrescribing of narcotics. I'll be – on the federal level it is permitted. So if your – if your state and your, you know, allows you to and your system meets

the requirements for the federal and local guidelines to prescribe narcotics, great, you can count those as ePrescribing events. If not, you can't count that as particular ones. But as I mentioned I'd be surprised if the only thing your docs prescribe is narcotics.

Karrie Chubb: No. No, you're correct they don't, it's just that that's of the larger portion of our Medicare Part B patients that's where we're at with those patients. But, you know, you are correct we prescribe other things. It's just not necessarily that demographic and we worry about reaching our – the required number within that demographic.

Aucha Prachanronarong: So, in addition to that if you believe that you can't electronically prescribe for at least ten Medicare beneficiaries in a six-month period, there is a hardship exemption available that you can request for the 2013 and the 2014 payment adjustment.

I can't – I think it's – I can't electronically prescribed due to state, local, federal law or regulation which would include, you know, laws or regulations in your area that do not allow the electronic prescribing of controlled substances, but this is a hardship exemption that you'll have to request when once we make that announcement that's available for request.

Karrie Chubb: OK. And with – if we qualify for that hardship then do we fall into the 1 percent reduction?

Aucha Prachanronarong: If your hardship is approved then you would not be subject to the 1 percent reduction for 20 or I guess the 2013 it would a 1-1/2 percent reduction and on for 2014 it would the 2 percent reduction.

Karrie Chubb: Right. OK. And you think the – this hardship would be available, did you say April?

Aucha Prachanronarong: I think March 1st …

Karrie Chubb: March.

Aucha Prachanronarong: … Expect to be – to make that available. And again you have to request the hardship every year …

Karrie Chubb: OK. Thank you.

Aucha Prachanronarong: … that is applied.

Operator: And your next question comes from the line of Sue Bartoli.

Sue Bartoli: This is Sue Bartoli with Retinal Consultants of Arizona. And my question is regarding avoiding the ePrescribe 2013 penalty. I received some conflicting information about this. Of the 10 prescriptions that we would need to submit to avoid the penalty, can any of those be prescriptions that we would give, say, at a post-op visit?

I had previously have been told to bill the post-op with a penny charge and then add the G-code to it. But then I've also heard that that would not count, so I'm just wondering who's correct?

Louisa Rink: To the extent that the post-op visits are part of the global surgery period and you would not normally bill those, please do not start billing them.

Sue Bartoli: OK.

Louisa Rink: You need to attach whatever G-code it is to a visit that you would normally bill.

Sue Bartoli: OK. OK. All right. Thank you very much.

Operator: Your next question comes from the line of Virginia Camp.

Virginia Camp: I'm calling from Southern Oklahoma Surgical Center. And we are pre-standing ambulatory surgery facility and our question is, is there an incentive for ambulatory surgery facility with reporting? And as I look at the category two codes, I see very – many things that would apply.

Aucha Prachanronarong: Are you referring to PQRS or ePrescribing, I guess first of all?

Virginia Camp: We're not currently doing ePrescribing. We do not have an electronic record.

Daniel Green: Yes. No, there would not be an incentive available under either of these programs for you.

Virginia Camp: OK.

Aucha Prachanronarong: But there is – I believe there is a separate reporting program for ambulatory surgery centers and I've – none of us in the room have any knowledge of the specifics of that program, I believe.

Virginia Camp: Do you know how we could get in touch with somebody about that?

Louisa Rink: You need to take a look on the CMS Web site at the ASC page and it will have details there about the reporting which I believe started in January.

Virginia Camp: OK. All right. I guess that's all that we need to know then. I appreciate your time.

Daniel Green: Thank you.

Virginia Camp: OK.

Operator: Your next question comes from the line of Janine Maupin.

That question has been withdrawn. Your next question comes from the line of Carol Puerta.

Carol Puerta: Yes, hi. Carol Puerta, calling from Collins Medical. If we are attesting to Medicaid meaningful use this year, can we still qualify for the ePrescribe incentive?

Daniel Green: You can.

Carol Puerta: That was an easy answer.

Daniel Green: Happy caller, will you stay on the line for the rest of the time?

Carol Puerta: Absolutely. Thank you very much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Ellen Dodson.

Ellen Dodson: Hi. This is Ellen Dodson. I'm calling from Danville ENT Associates. And my question is, why can't we do something to correct some errors that were made? Because we were adopting some electronic medical record but I thought this particular doctor met the requirements for eScribing but as it turned out two of the ones we sent were medical replacement policies. We were under a lot of turmoil during all of these.

Daniel Green: Yes. I'm not a 100 percent sure I understand your question, could you try to rephrase it please?

Ellen Dodson: It's my understanding we cannot go back and add the G-codes to ones we know what eScribe, right?

Daniel Green: That is correct.

Ellen Dodson: Why is there not some kind of – something in place for errors made during a difficult time? I mean, I'm not – could have filed the hardship but I really thought he met it.

Daniel Green: Yes. Certainly can appreciate the frustration that you must be feeling and also the, you know, the issues surrounding some folks, you know, when their practice is moving or their system is down or what have you. The problem we have as you can imagine, Medicare receives – well Lisa how many millions of claims do we get a year?

Louisa Rink: That's billions with a B.

Daniel Green: OK. So it's billions with a B. And, you know, we have – and between PQRS and ePrescribing probably over 200,000 eligible professionals recording anywhere from a few to – in the hundreds or more of folks. So you can imagine the volume of claims we would have to get.

And the concern is it would tie up and it would crash our payment system, so not only would not be getting – likely they'll getting the disincentive for not reporting the eRx but the regular – the concern is the regular fines would be process to the timely way.

And obviously its Medicare's intentions to try to get payments out, you know, to providers as quickly as possible to, you know, to allow their practices to function and thrive.

So the, you know, when PQRS started in 2007, the policy was and has – and has continued especially if the program's grown that we cannot allow folks to resubmit claims solely to the purpose of adding a data quality code.

Ellen Dodson: OK. I just – I just think it's horrible that they start so many programs that nobody can keep up with all the data. I mean you've got clocks on CMS Web site, countdown for 5010 and they're – the information for eScribing was so buried down in program that I didn't even know that Medicare replacement policies didn't count.

Aucha Prachanronarong: I think we'll have to have our help desk contact you to discuss some more of the specifics of your situation. Can we get your name and …

Elia Cossis: E-mail or phone number.

Aucha Prachanronarong: … e-mail or phone number?

Susan Merricks: Yes. Ellen was filling in for me, my name is Susan Merricks, M-E-R-R-I-C-K-S, and it's – and work for Danville, D-A-N-V-I-L-L-E, ENT, which stands for Ear Nose and Throat, Associates. And my e-mail address is entdocs@gamewood.net.

Daniel Green: OK. Thank you.

Susan Merricks: Thank you very much; you all have a good day.

Daniel Green: You too, thank you.

Operator: Your next question comes from the line of Lorraine Lessani.

Lorraine Lessani: Good morning my – I have a question. I would like to have the phone number of the QualityNet Help Desk, I'd like – I'd like to make a suggestion that when it is read that they don't read the number so quickly and that is repeated the second time.

And I would like to make a suggestion because when I signed up for the Webinar of that conference, it would be nice if on the confirmation sheet they tell you what Web page to go to in the slideshow. I did miss the entire slideshow. I sat and listen and I wasn't able to find the slideshow presentation.

So, it would be nice on the registration form to say go to www.cms.something and then the slideshow presentation and click it, so that we are ready to go and to view it when the presentation begins.

You know, I've been on the Web site, you know, googling slideshows on Web site and I plan on going through it after this meeting finishes but it would be nice if we had that information handy on the confirmation sheet.

Geanelle Herring: Hi. This is Geanelle Herring. I'm going to answer your question, both of them. The first answer for QualityNet Help Desk, the number's 866 …

Lorraine Lessani: Yes.

Geanelle Herring: … 288-8912 and they are available from 7a.m. to 7 p.m. Central Standard Time, Monday to Friday.

Lorraine Lessani: OK. Thank you.

Geanelle Herring: And with regards to the presentation, the URL to access the presentation is on the conference registration site. So, when you pull up the link for whichever call you'd like to attend you'll come to call site, which gives you all the particulars for each call. And each call does list the URL for where you can find the presentation.

Lorraine Lessani: All right. Somehow I missed that. And it would have been nice to have had it.

Geanelle Herring: Right.

Lorraine Lessani: So, all right. Well, I thank you very much.

Geanelle Herring: You're quite welcome.

Operator: Your next question comes from the line of Leslie Witkin.

Leslie Witkin: Hi. This is Leslie Witkin with Physician's First. I have a question about the new exemption for the six months payment adjustment reporting period, the specific one the EP prescribed fewer than 100 prescriptions during the six-month period. What kind of documentation would you expect providers to enter if they apply for that exemption at the communication support page?

Aucha Prachanronarong: It's just an attestation.

Leslie Witkin: Just to say they actually had less than 100 prescriptions, I think – I've had providers saying, "Well what do I need to actually count the number of paper prescriptions that I've done during the six months?" Which administratively would be impossible.

So your expectation is just for them to attest to the fact that they have less than 100 prescriptions?

Aucha Prachanronarong: That's correct.

Leslie Witkin: I'm sorry, I didn't hear you.

Daniel Green: That's right.

Leslie Witkin: OK.

Daniel Green: We may also require a complete DNA sequence of each doctor. In the meantime, we'll just go with the first answer.

Leslie Witkin: Are you actually going to the reviewing claims or prescription data to ensure that in fact they were less than 100 although I don't know that that would be possible either? I guess I just want to confirm that if a provider applies …

Daniel Green: I can …

Leslie Witkin: … and attest to the fact that they were less than 100 that would be sufficient?

Daniel Green: If you can imagine it's like a pathology doctor says they have less than a 100 prescriptions that's pretty obvious. If an internal medicine doctor says that they have less than a 100, you know, maybe they do not …

Leslie Witkin: You don't have to question it, I get it. All right, but as far as – there's no specific documentation requirement but I see exactly what you're leading to.

Daniel Green: Just the attestation.

Leslie Witkin: All right. Thank you very much.

Daniel Green: Thank you.

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

Jennifer Montgomery: Hi this is Jennifer Montgomery from Beth Israel Continuum Healthcare. I caught the tail end of a question before and I apologize, I'm usually a little more attentive. But I know that on one of the calls we did discuss the post-op visit and we were specifically told that we could do it, do the ePrescribe for the six months with that. You're saying we cannot, is that correct?

Daniel Green: That is correct.

Jennifer Montgomery: That's correct.

Daniel Green: But it does normally build a post-op visit don't go solely in the system.

Jennifer Montgomery: OK.

Daniel Green: But we will accept on ePrescription with any billable Medicare service to avoid the payment reduction.

Jennifer Montgomery: OK. So if my doctors routinely billed post-op visit would that going to be …

Louisa Rink: The extent that you would normally do when receive payment for a service then you can bill the code with that. However, to the extent that that post-op service would be included in the global period and not separately billable …

Jennifer Montgomery: OK.

Louisa Rink: … then do not bill it, simply to send them an ePrescribing code.

Jennifer Montgomery: OK. That's pretty clear with that. OK. Thank you.

Operator: Your next question comes from the line of Laurie Sinigit.

Laurie Sinigit: Hi. This is Laurie Sinigit. I think that it's my turn Dr. Green?

Daniel Green: We hear you.

Laurie Sinigit: OK, great. OK. I have a question actually it ties in the one of the previous comments or question with respect to the G-code. So, I mean I think it's really helpful that obviously the physicians can report the – for ePrescribing the G-code even if it's not for a particular service in the denominator. I guess I'm just wondering, I'm a little worried from some of the feedback we've gotten from this past year that the G-codes are not getting through the clearinghouse.

I know you know like a lot about this from the quality experience. But I am a little concerned about it; I want to make sure that we work with you to message so that we can get the word out. I want to check on a few things, so if the G-code gets through on – and it does make it through and it's on the EOB that's not an indication that's counted, it appears on the EOB and that's helpful. But as far as it actually being counted 100 percent, that doesn't happen until the feedback report in the fall, is that correct?

Daniel Green: Not exactly. So if you – if you submit the G – you're talking about ePrescribing, so if you submit the …

Laurie Sinigit: Yes, sorry about ePrescribing.

Daniel Green: OK. So if you submit – if your doc or you submit the G-code on your claim you should get back on that claim and N365 for that particular quality data code.

Laurie Sinigit: Right.

Daniel Green: But it basically needs just a non-billable service, whatever that means we got that code. Now, what it does not tell you however is that you reported the proper G-code. So let's – the G-code for ePrescribing as you know is GA 553, right?

Laurie Sinigit: Right.

Daniel Green: So, if you happen to make a mistake and you wrote GA 543 let's say …

Laurie Sinigit: Yes.

Daniel Green: … you would likely get a – that same – you just get the same N365 but it's not an acceptable bill code, it's not an acceptable G-code for that ePrescribing measure. So, assuming that the G-code GA 543, I'm making this up obviously, but let's say that goes with one of the PQRS measures, it would …

Laurie Sinigit: Right.

Daniel Green: … it would come back as we got your G-code but again when we went to count that ePrescription obviously it doesn't make sense for the ePrescribing measure it's the wrong G-code.

So again, the entry 65 tells you we received a quality data code that's not payable and all that kind of stuff but it doesn't guarantee you 100 percent that you submitted the correct G-code.

Laurie Sinigit: OK. That's helpful to know. I'm going to talk to you guys maybe offline to make sure we can message like just alert the physicians to this because again we're getting some inquiries about all my G-code didn't go across or I guess in this case it went across but it wasn't the right one so maybe any tips for how I guess they have to review their EOB really carefully to make …

Daniel Green: Again, that's definitely helpful to make sure that we got the G-code but it wouldn't necessarily tell them that it was the correct G-code. So, they probably would want to review it with their billing folks, you know, or maybe even have on the super bill, the GA 553 that they can circle when they ePrescribe. I mean that's personally what I would do.

Laurie Sinigit: The EOB won't actually show that which G-code was reported, it will just show that a G-code was reported.

Daniel Green: That's right.

Laurie Sinigit: And the other thing I just wanted to raise in sort of same vein but a little bit different is another reason that these all cause some anxiety for us is that right now – and one of the callers mentioned 5010, there's a lot of problems going on with clearinghouses, physicians who use clearinghouses successfully get their claims processed in a 5010 format and they're not reaching – they're not even reaching Medicare.

And so I'm very worried that this year, I think this 2012 year and reporting and things kind of falling through the cracks because there's all – there are 5010 that's going on, so I just wanted to kind of sensitize you to that and again maybe we can talk about that later but it's really a problem. And we've got to get OESS involved and it's just another thing to keep in mind because if the claims are not even making it through having noticed like with the 5010 like, it means they're dropping off and it's a lot to keep for the doctors to keep track off.

Daniel Green: So we're having – I'm sorry, we're having a little internal discussion while you were asking your last question because there's some thought that the G – that the actual G-code will show up on the …

Louisa Rink: On the remittance advice just like any other claim line it's going to show up what you billed on the remittance advice, so will the G-code. It's a claim line like any other and you'll see the N365 thing it was denied. It is on the remittance advice …

Laurie Sinigit: You guys kind of point out something like some kind of plain English fact sheet about – because of all the problems that, you know, obviously some of the submitters have had to make sure that that goes in this current year prior to June 30th. Actually, you know, look at the stuff before it goes through because it seems like the only proof of way to know if you met everything is when you get the – when you get the feedback report, unless you've done some kind of internal audit, which is an awful lot of work. I know I just want to work with you guys on that.

So the other thing I was just mentioning is 5010, there's a lot of stuff that's going on in 5010 and if I'm – physicians are experiencing major problems with clearinghouses not getting their claims even into the claim floor of the Medicare contractors and that compile, you know, on top of the ePrescribing stuff could be, you know, could be something that is a real problem that we're not yet aware of.

I'm just sensitizing you to that because I didn't know if you're aware of that.

Louisa Rink: We certainly are very aware of the 5010 transition and some of those other issues but we are, as you probably know, allowing a delay of implementation of 5010, so I don't know what that might mean for other insurers but for us we're still accepting, I think it's 4010 A1. OK?

Laurie Sinigit: Yes, I'm aware of the – I'm aware of the enforcement delay that's helpful but look I'm saying some of the things aren't – some of the claims aren't making their way from the clearinghouse over to Medicare contractors.

And so this is resulting in doctors having to go back and they're working through these issues but I guess I'm just fearful that, you know, a G-code could be missed – it could have been stripped off or missed during this transition period with 5010. Does that make sense?

Louisa Rink: Yes. I mean certainly anything is possible when you're going through the software changes. Certainly we don't know what may or may not be happening at the different clearinghouses because it's before it hits our system. But again it is important to be sure that those are going through because as we've been emphasizing you cannot resubmit a claim simply to add a G-code.

So, if the clearinghouse is stripping it off then that is a represent to loss opportunity.

Laurie Sinigit: OK. We'll follow up with you. Thank you.

Operator: Your next question comes from the line of Nikki Moore.

Nikki Moore: Hi, this is Nikki Moore. I was wanting to ask a question about claims-based reporting for the ePrescribing program. Hello?

Daniel Green: Go ahead.

Nikki Moore: We had decided to do registry-based reporting this year for the majority of our doctors that met all the reporting requirements last year in 2011 but we had a few slip through our system this year at the very beginning and we'd stopped those. Can we call clerical reopening and get that G-code, that GA 55533, removed from those claims?

Louisa Rink: I'm not clear to why you want to have the G-code removed?

Nikki Moore: We have reporting a registry based this year, again …

Louisa Rink: It won't hurt you to have those.

Nikki Moore: It won't hurt if we have those.

Daniel Green: And are you reporting registries on the incentives or are you trying to avoid current 2013 penalty?

Nikki Moore: We're trying to avoid the penalty because we're also reporting meaningful use.

Daniel Green: OK, because you can't reduce the registry to report for the first six months to avoid the penalty for 2013. If you do 25 prescriptions via registry during the whole calendar year 2012, you'll avoid the 2014 …

Nikki Moore: Right.

Daniel Green: … but a way to get out of 2013 if you're not already exempt would be to report, you know, ePrescribing 10 times during the first six months via claims.

Nikki Moore: OK. But for the ones that met their 10 last year and the 25 total, wouldn't they already be exempt from the 2013?

Daniel Green: They would.

Nikki Moore: OK. So those are the ones we're reporting in registry.

Daniel Green: OK, that's fine.

Nikki Moore: And but we're also reporting, you know, the meaningful use, so we know we wouldn't get the incentive but some of those slipped through the cracks and ended up reporting claims-based also so you said that's not going to hurt us?

Daniel Green: No. You could report via claims, via EHR, and registry. We'll take the most favorable one for you.

Nikki Moore: And so if it all happens at the same time, it's all right?

Daniel Green: Right. The only thing we won't do is if you do let the five points, I'm sorry, five G-codes to your claims and we do six via registry, and two via EHR, we won't add the different methods together.

Nikki Moore: No, no, no.

Daniel Green: But we'll take the most favorable.

Nikki Moore: Yes, sir. OK, well, that's what we're doing then. Thank you so much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Kris Dittrich.

Kris Dittrich: Hi, my name is Kris Dittrich. I'm with Washington Physician's Group for multi-specialty practice. My question is I have been looking online at the CMS-approved – CMS-approved EMR that can send information through registries and our vendor had said that we're not going to be eligible or they're not going to have – be approved until late 2013. And my concern is, is 2014 when we're going to start getting penalized for not getting reporting data?

Daniel Green: OK. So 20 – you have to report in 2013 to avoid getting penalized in 2015 but I'm a little confused about the first part of your question. Are you trying to report via registry or are you trying to report from your EHR, how are …

Kris Dittrich: Usually – well, it's through – ideally we'd want to go through registry or through EMR where we have McKesson practice partners and we're getting our clinical elements in clinical data, we're working on getting that streamlined and our report for fashion but they said they're not going to be an approved vendor for CMS registry until possibly late or in 2013.

And I just was wondering is that going to be a problem or is that something that we need to work with our vendor or they need to work with CMS on?

Daniel Green: A couple of things, first of all, if they applied to become a qualified, either they're in a submission vendor or electronic health record for 2013 we would be testing them later. Well, they're, excuse me, applying to become a qualified EHR vendor, we would be testing them later this year so you would know about that sometime in January of 2013.

Kris Dittrich: OK.

Daniel Green: If they're applying to be data submission vendor which is kind of a registry for EHRs, we would – we will be doing that testing most likely in 2013 so you may not know that until mid-year but they don't – but they submit their data the beginning of the following year. So they would submit their 2013 data in early of 2014.

Now, another you could do is you could contact one of the local registry – or not local. You can contact one of the registry that's qualified, many of them get their information by the docs entering the information on a Web portal, so they could begin reporting even this year, even just sitting down with their EMR and, you know, looking up diabetic patient or what have you and reporting that in through the Web portal and then the registry would submit the information for the doc.

Kris Dittrich: OK.

Daniel Green: Thank you.

Kris Dittrich: Thank you.

Operator: Your next question comes from the line of Susan Edelkamp.

Susan Edelkamp: Hi. This is Susan Edelkamp with Gregory L. Henderson, MD. Hello?

Daniel Green: Hi, Susan. Yes, hi, we're here.

Susan Edelkamp: Hi. OK. I'm still back on case line of the seminar and under the eRx and in regards to six months of where the 2013 payment adjustment only and that's regarding to the billable Medicare Part B service – during the six months piece here, are you saying we did not need to send a numerator with the G-code during this time period?

Daniel Green: The numerator is the G-code.

Susan Edelkamp: I mean the denominator, I'm sorry.

Daniel Green: Well, you need to have some sort of billable service but it doesn't have to be one of the codes that appear on the denominator of the measure.

Susan Edelkamp: OK. All right, so you don't have to have the denominator during the first six months of June to or from January to June? But then from July to December, you do have to have the denominator?

Daniel Green: So, again, if you're trying to avoid the payment adjustment only, it could be with any Medicare billable surcharge. You can – that you ePrescribe, you can send that to G-code.

If you're trying to earn the incentives and avoid the 2014 payment adjustments, you have to have 25 prescriptions that are written, I'm sorry, that you have prescription written during 25 visits that appear in the denominator of the measure.

Susan Edelkamp: Got you. OK. Thank you very much.

Daniel Green: You're welcome, thank you.

Operator: Your next question comes from the line of Michael Fox.

Michael Fox: Hi. I'm calling from Comprehensive Breast Care in Detroit, Michigan.

Daniel Green: This isn't Michael J. Fox, is it?

Michael Fox: Yes. Yes, one and the same. I've decided to slum it a little bit and try to do – try my hand at physician billing.

Daniel Green: All right. I watched you in...

Michael Fox: I'm just calling, I'm just receiving – I've received a couple of e-mails from a couple of different advocacy groups indicating there's some progress being made to perhaps and allow providers to incorrectly to use their group NPI when filling a hardship application to correct this. And I'm just wondering if there's any prior – if that is true, you guys are considering adding and working toward that end?

Aucha Prachanronarong: Yes, we are looking at that issue.

Michael Fox: OK. OK. And I would imagine it's going to, you know, communicate your progress through this, the usual channels then?

Aucha Prachanronarong: Yes, that's assumed.

Michael Fox: OK. OK. That's very encouraging and I thank you for considering that.

Daniel Green: By the way I love you in "Back to the Future."

Michael Fox: Well, the third one was my best one, I thought. Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Gabby Villanueva.

Gabby Villanueva: So this is Gabby Villanueva, calling with Dr. Bocanegra's office in Laredo, Texas. I have a question on group, the preventive measures. Hello?

Daniel Green: OK. Yes, we're here.

Gabby Villanueva: When all of the measures are not completed on the first visit, is it OK that we complete like, let's say when we're going to do the colorectal cancer screenings. If on that visit the doctor decides that he needs to send out for it or whatever, do we document it on the following visit that they come because let's say right now it's early on the year, so we are going to see the patient, you know, in like a month from now let's suppose. Do we just kind of complete what we didn't finish off on the next visit or do we have to complete it on that first time that we report?

Daniel Green: No. You don't have to complete it on the first time, I mean obviously it's easier for the – for the doctor to report everything, you know, when he or she sees the patient but …

Gabby Villanueva: Yes.

Daniel Green: … you know, if you send them for their mammogram or they come back, you know, obviously you can add the mammogram measure, you know, later in the year.

Gabby Villanueva: OK. I just wanted to confirm that. That's what the help desk let me know but I just – I said maybe we're doing this wrong. OK. Thank you so much.

Daniel Green: No, you're welcome. It's just – it's just a little tricky to track, patient this needs this, that patient needs that.

Gabby Villanueva: Yes. Yes. But I guess it's better than putting like an 8P and just, you know, not dealing with it.

Daniel Green: Yes, I mean obviously that's – yes, we would rather have the better data but again …

Gabby Villanueva: Yes.

Daniel Green: … whatever we can do.

Gabby Villanueva: OK. All right. Thank you so much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of (Bridget Gary).

Daniel Green: Bless you.

Jenna Dewolf: I'm Jenna Dewolf from (Mitta). I was calling in regards to one of the hardship exemptions. We were – we were under the impression that it was – if the eligible professional had less than 100 eligible visits that's in the denominator for the measure whereas we were just – you were just talking to another person earlier and they were discussing 100 prescriptions written during that timeframe. So, I was just wondering if I can get some clarification on that.

Daniel Green: So if they have less then 100 visits to begin with then they would not be included, that they would be screened out if you will. It's like they don't have 10 percent of their charges comprised of codes in the denominator, they wouldn't be eligible for the payment adjustment.

Jenna Dewolf: So those are two separate exemptions then?

Daniel Green: Well, the first one is something we look at the 100 – the 100 visits, you know, we can total off if they're 100 visits or not for the services. And if there aren't then that it, the person's removed from the payment adjustment.

If there are 100 visits they could be – they could come to pass but the eligible professional doesn't have at least a 100 ePrescribing events, we wouldn't know that without them telling us, you see what I'm saying?

Jenna Dewolf: Right.

Daniel Green: So they have that something that they would attest to.

Bridget Gary: OK. This is Bridget. Hi. When you talk about 100 events, are we saying that for the instance of prescribing; ePrescribing, say for one visit you prescribe three meds? That's only going to count with one G-code so that's one instance that you've been prescribing, correct?

Daniel Green: That is correct.

Bridget Gary: Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Joanne Warren.

Joanne Warren: Hi. My name is Joanne Warren. I'm a practice manager at Dalton Medical. I have two questions and I think one was already actually answered with another question but I'm going to be doing claims-based eRx reporting and we're going into an electronic medical record, you know, hopefully within the next six weeks and it would be a registry reporting. But I guess it's OK to be able to do claims and registry.

Daniel Green: Again, the only way to avoid the 2013 payment adjustment is if you have already avoided it by doing 25 ePrescriptions last year would be to do 10 ePrescription for the first six months of this year via claims.

Joanne Warren: We did it last year, so …

Daniel Green: OK. And so if you want to report for the year to get out either early incentive and/or to get out of the 2014 payments adjustment, you can do that if your system is qualified either as a direct report or you could do it through a data submission vendor if your EHR is hooked up with the data submission vendor, so or you can do it through claims.

Joanne Warren: OK. And the other question and I learned this today, someone has said to me the problem with 5010 is that usually you reported the G-code with a penny but I'm not sure if this has to do with the clearinghouse or CMS but instead of a penny, you have to do a dollar. So, I didn't know if you have heard anything to do with that?

Daniel Green: Well, I knew that inflation was bad especially with gas prices and all but I wasn't aware of it went up 100 – 1,000 percent. I don't know the answer to that actually.

Joanne Warren: I'm not sure if that was to their particular clearinghouse that they use for billing but that – if you're billing under 5010, it would not accept the penny. So I didn't know – I know a lot of us have tested in them and doing the 5010 and I'm not sure if that's why people were having trouble but I didn't know if you know anything about the dollar.

Louisa Rink: So my understanding in the past when clearinghouses have trouble with it and it's always been clearinghouses not CMS. They just wanted any amount at all in there so the direction is actually to put – I think it says something like a negligible amount or something like that in there. It's going to get denied anyway.

Joanne Warren: Correct.

Louisa Rink: I just don't want to jack up the dollars that have been denied but we don't have an issue with accepting zero so it's – whatever it is, it's a clearinghouse thing.

Joanne Warren: And so we should probably talk with our clearinghouse.

Louisa Rink: That would be my advice, yes.

Joanne Warren: OK. And I did have one other question. If you were going to electronic medical record and test for meaningful use this year, does that make you not eligible for the eRx incentive?

Daniel Green: That's correct. If you're doing a Medicare meaningful use, you cannot earn an incentive for the eRx but you still could get the penalty so you make sure, you know, still want to submit those G-codes.

Joanne Warren: Correct. OK, so we won't get – if we do meaningful use this year, 2013, we don't get the money from doing meaning the eRx from last year which we need to pay out this, usually on July or August? Or is it …?

Daniel Green: OK. So now you're all over your what if's. So if you do 2012 meaningful use, so you use eRx Incentive Program …

Joanne Warren: Yes, OK.

Daniel Green: … you cannot earn a 2012 eRx incentive …

Joanne Warren: OK.

Daniel Green: Because then again if you're doing Medicare, if you're Medicaid that's a different story. So if you earn an incentive for 2011, last year, you will still – you'll still get that in …

Joanne Warren: OK.

Daniel Green: … August, September, October of this year.

Joanne Warren: Right, OK. So we're going to do meaningful use. So we have to – so we have to report that we're doing it but we won't get the incentive if we do meaningful use this year. OK. Thank you very much.

Louisa Rink: Thank you.

Holley, we have time for just one more question.

Operator: OK. And your final question comes from the line of Kelly Gentry.

Kelly Gentry: Hi, can you hear me?

Kim Schwartz: Yes.

Daniel Green: We can hear you.

Kelly Gentry: I think that last question I was about to withdraw but I think that that last question my have clarified. In a previous caller's question she said that if she attests for Medicaid meaningful use, she still could get the Medicare eRx incentives and that differs from some other information that we had received. And so I want to clarify that I heard that correctly.

Daniel Green: So again, Medicaid meaningful use with Medicare eRx, it's good if you can get both.

Kelly Gentry: OK, perfect. That's what I needed to know.

Daniel Green: By the way, are you using Verizon?

Kelly Gentry: No.

Daniel Green: Because we could really hear you very well, sorry, you find that – I'm giving Geanelle palpitations by adding my little loving to these calls.

Kelly Gentry: I think I'm just really loud.

Daniel Green: No, I'm kidding. Thank you.

Kelly Gentry: Thank you.

Geanelle Herring: Thank you. I'd like to thank everyone including the subject matter experts here joining us for the part – for their participation in the question and answer portion of today's call.

The audio file and transcript will be made available shortly at http://www.cms.gov/pqrs on the CMS Web site.

If you are unable to ask a question of the subject matter experts gathered here today, please feel free to contact the QualityNet Help Desk at 866-288-8912.

To ensure that the National Provider Call program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with us today. Evaluations are anonymous and strictly voluntary. To complete the evaluation visit http://npc.b, as in boy, L – H as in Harold, T as in Tom, ech.com/. And select a title for today's call from the menu.

All registrants will also receive a reminder e-mail within two business days of today's call. Please disregard this e-mail if you have already completed the evaluation.

We do appreciate your feedback and we'll see you on March the 20th.

Operator: Thank you for your participation. You may now disconnect. Speakers, please hold the line.

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