Centers for Medicare & Medicaid Services
2011 Physician Quality Reporting System and Electronic Prescribing Incentive Program
National Provider Call
Moderator: Geanelle Herring
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Contents

Operator: At this time, I would like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing 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. Thank you for your participation in today's call. I will turn the call over to Geanelle Herring. Thank you, ma'am. You may begin.

Introduction

Geanelle Herring: Thank you, Holly. Good afternoon, everyone, and welcome to the 2011 Physician Quality Reporting System and Electronic Prescribing Incentive Program National Provider Call. My name is Geanelle Griffith Herring and I will serve as your moderator today. Following a few announcements and a presentation that will provide an overview of the Medicare Physician Fee Schedule Final Rule to address the 2012 Physician Quality Reporting System and Electronic Prescribing Incentive Program changes, the lines will be open to allow you to ask question of CMS subject-matter experts.

With me here today are the CMS subject-matter experts on the Physician Quality Reporting System and Electronic Prescribing Incentive Program who have been instrumental in developing the policies, procedures, measures, and specification guidelines of both programs. I will now turn the call over to Daniel Green. Dr. Green?

Announcements

Daniel Green: Thanks, Geanelle. Welcome everybody, and we appreciate your continued interest in the Physician Quality Reporting System and Electronic Prescribing, or eRx Incentive Program, as we call it.

As many of you know, the final rule was published in the Physician Fee Schedule on November 1st. This will be available in hard print on or about November 28th. However, it is available electronically now and we encourage you to check it and to look out for details in the final Medicare Physician Fee Schedule Rule.

In order to make sure we have plenty of time for questions, I will limit my remarks and turn the meeting over to Diane Stern for some additional announcements. We will then proceed to a short presentation. Again, I would like to thank you for dialing in this afternoon.

Diane Stern: Thank you, Dr. Green. The Center for Medicare and Medicaid Services would like to announce to eligible professionals and group practices that there are many requests for significant hardship exemptions for the 2012 e-prescribing payment adjustment period that was extended for one week and ends tonight, November 8th, at 11:59 p.m. Eastern Standard Time. We would like to remind eligible professionals that it is not too late to participate in the 2011 E-Prescribing Incentive Program to potentially qualify for a 2011 e-prescribing incentive and be excluded from the 2013 e-prescribing payment adjustment.

Eligible professionals have until December 31, 2011 to meet the requirements for the 2011 incentive and thus be excluded from the 2013 payment adjustment. Some reminders I would like to announce. We would like to remind eligible professionals to be sure to update their information on the Provider Enrollment, Chain, and Ownership System, known as PECOS. The provider information used to populate the Physician Compare Web site comes from the PECOS and an external data source. In order for a physician or other healthcare professional's information to appear on the Physician Compare Web site, their enrollment records and PECOS must be current and in approved status. A valid physical location or address must be identified and the provider must have a valid state license and NPI.

Please note there is a 45- to 60-day lag for new enrollment, updates, and changes to take place in PECOS. You can update your information through Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do. Please remember that the CMS Web site is a primary and authoritative source for all publically available information and CMS reported educational implementation support materials for both the Physician Quality Reporting System and the E-Prescribing Incentive Program.

Measure specifications and related materials are updated each program year. It is the responsibility of the participants, not CMS, to ensure you are using the current year materials since codes and requirements may change from one program year to the next.

Always reference the current year document. Please watch for updated 2012 materials to be posted before the end of the year. Eligible professionals should check the Spotlight page for updates on both the PQRS and the E-Prescribing Program Web site.

Our next National Provider Call will be from at 1:30 to 3:00 p.m. Eastern Standard Time on December 20th. The topic of discussion will be EHR and Registry-Based Reporting. I would now like to turn the presentation portion of the call over to Christine Estella, who will be presenting on the 2012 Medicare Physician Fee Schedule Final Rule.

2012 Physician Fee Schedule Final Rule: Quality Reporting Initiatives

Christine Estella: Thanks, Diane. Good day, everybody. Now on to our presentation, the 2012 Physician Fee Schedule Final Rule, which has final requirements for some of our quality reporting initiatives here at CMS. We will turn to slide 3, which is our agenda. We finished our announcement. We will first go over the E-Prescribing Incentive Program and then turn to the Physician Quality Reporting System as well as some of the changes we are making to the Medicare EHR Incentive Program for the 2012 payment year. After the presentation, we will answer any questions you may also have.

Now on slide 5, the E-Prescribing Incentive Program. The E-Prescribing Incentive Program was established in 2009. It seeks to encourage the use of electronic prescribing by providing incentives and payment adjustments based on whether eligible professionals meet the criteria for being successful electronic prescribers. We have incentive amounts running through 2013. So we have two more years' worth of incentive: 2012 and 2013. As you can see on slide 5, it's one percent for 2012 and 0.5 percent for 2013. We also have payment adjustments in 2013 and 2014. And, as you are all aware, we have a

payment adjustment for 2012. The payment adjustment for 2013 is 1.5 percent, and the payment adjustment for 2014 is two percent.

There are no incentives or payment adjustments scheduled past 2014 so this final rule sets out the requirements for the programs up until 2014. That includes the final requirements for the 2012 and 2013 incentives as well as the 2013 and 2014 payment adjustments.

On the bottom of slide 5, there is a direct link to our Web site.

On slide 6, we have the characteristics of our e-prescribing measure for 2012 through 2014. It's pretty much the same as the one we finalized in 2011. The numerator code is G8553 and the denominator codes are provided below. Please remember that in order to become a successful e-prescriber within our program for the purposes of earning incentive and payment adjustments, one would report the e-prescribing measure, the specification for which is on slide 6. There is more information about our measure on our Web site.

Slide 7 has several tables that list the criteria for being a successful electronic prescriber for the 2012 and 2013 incentives. As you can see, the reporting periods for these incentives are a 12-month reporting period, so it would be January 1 through December 31, 2012 for the 2012 incentive and January 1 through December 31, 2013 for the 2013 incentive. The requirements for reporting are the same. It would be to report the e-prescribing measure's numerator for at least 25 unique denominator-eligible visits. You can report this measure via three reporting mechanisms: claims, registry, and EHR. This year, we have a new EHR option that's direct EHR or EHR data submission vendor. You can report through either of those.

On slide 8, we have our criteria for being a successful electronic prescriber for the 2012 incentive. On slide 9, we have our criteria for being a successful electronic prescriber for the 2013 incentive for GPROs. This only relates to GPROs that have elected to participate as an e-prescribing GPRO.

We have two criteria, depending on the group size. One size is the smaller group practices consisting of 25 through 99 eligible professionals. You report

the measure for at least 625 unique denominator-eligible visits. Once again, the reporting period is a full calendar year. So it's a 12-month reporting period from January 1, 2012 through December 31, 2012 for the 2012 incentive and January 1, 2013 through December 31, 2013 for the 2013 incentive. You have three reporting mechanisms available to you that are like individual eligible professionals: claim, registry, and EHR.

Group practices comprised of 100 or more eligible professionals have different reporting criteria. The reporting criteria for those group practices are to report the e-prescribing measure's numerator for at least 2,500 unique denominator-eligible visits. That's via claims, registry, and EHR. Again, you have the 12-month reporting period.

Skipping to slide 10, this slide looks at criteria for being a successful electronic prescriber for the 2013 payment adjustment for individual eligible professionals. Through these payment adjustments, we have a 12-month reporting period; so it's January 1, 2011 through December 31, 2011. That reporting period is actually happening right now; it's the one finalized in the 2011 Physician Fee Schedule. You can still avoid the payment adjustment, as Diane mentioned. That way, you report the 2011 e-Prescribing measure's numerator code at least 25 times for encounters associated with at least one of the denominator codes to be the same as meeting the criteria for 2011 e-prescribing incentive.

In the Physician Fee Schedule that we just displayed for 2012, we also finalized a 6-month reporting period, which is another opportunity to get out of the 2013 payment adjustment. That 6-month reporting period runs from January 1, 2012 through June 30, 2012. The reporting mechanism for that is claims, and only claims. You would report the electronic prescribing measure's numerator code at least 10 times. This is without regard to whether or not the visit is associated to one of our denominator codes in the e-prescribing measure.

On slide 11, we have the criteria we finalized for being a successful electronic prescriber for the 2014 payment adjustment. Now, as already stated, we wanted to parallel the criteria established for the 2013 payment adjustment. So

once again, we have that 12-month reporting period for the 2014 payment adjustment, and that would be from January 1, 2012 through December 31, 2012.

The reporting criteria would be to report on the e-prescribing measure's numerator code at least 25 times for encounters associated with at least one of the denominator codes, which are the same criteria as the 2012 e-prescribing incentive. You have the three reporting mechanisms available to you for the 12-month reporting period; you can use claims, registry, or EHR to report the e-prescribing measure. We also finalized a 6-month reporting period that runs from January 1, 2013 through June 30, 2013. The only reporting mechanism for that is claims, and an eligible professional would report the electronic prescribing measure's numerator code at least 10 times. Once again, this is without regard to whether or not the visit is associated with one of the denominator codes in our e-prescribing measure.

On slide 12, we list the criteria for being a successful electronic prescriber for the 2013 payment adjustment for GPROs. On slide 13, we list the criteria for being a successful electronic prescriber for the 2014 payment adjustment for GPROs. Once again, we are finalizing another opportunity for GPROs to get out of the 2013 payment adjustment. We have a 6-month reporting period for that—January 1, 2012 through June 30, 2012—and then there are two different criteria depending on your group size. The group practice would report on e-prescribing measures at least either 625 times or 2,500 times, depending on the size of the group. Please also remember, as Diane noted earlier, that the reporting period is currently ongoing for the 12-month reporting period for the 2013 payment adjustment so it is still possible to get out of the 2013 payment adjustment for reporting this year.

On slide 13, as you can see, we have two different reporting periods as well. We have a 12-month reporting period from January 1 through December 31, 2012 and a 6-month reporting period from January 1 through June 30, 2013 for the 2014 payment adjustment. For the 12-month reporting period, all reporting mechanisms are available: claims, registry, and EHR. You would report the e-prescribing measure's numerator at least 625 times or 2,500

times, depending on your group size, for at least one visit associated with one of the denominator codes in our measure, and that's for the 12-month reporting period. However, if you wanted to use a 6-month reporting period, the visit does not need to be associated with one of our denominator codes. Again, the number of times you report is the same for the 6-month reporting period, so it's 625 times for group practices of 25 through 99 eligible professionals or 2,500 times for group practices of 100 or more. Once again, the only reporting mechanism available for the 6-month 2014 payment adjustment reporting period is claims.

Slide 14 lists the finalized significant hardship exemptions for the 2013 and 2014 payment adjustments. Three of these were finalized previously for the 2012 payment adjustment. The first is the eligible professional or group practice: practices in a rural area with limited high-speed Internet access. The second is the eligible professional or group practice: practices in an area with limited available pharmacies for electronic prescribing. The third is an inability to electronically prescribe due to local, State, or Federal law or regulation. The fourth is for eligible professionals who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period. The deadline to submit these requests for significant hardship exemptions for the 2013 payment adjustment is the end of the 6-month reporting period, so that's June 30, 2012. For the 2014 payment adjustment, it would be June 30, 2013.

We are receiving these requests through our Communication Support Page, just like the 2012 payment adjustments we finalized this past year. There's a link to our Communication Support Page on slide 14. The Communication Support Page will be available to accept requests for significant hardship exemptions starting in spring 2012.

Now, if I can move on to the Physician Quality Reporting System on slide 17. Established in 2007, the Physician Quality Reporting System is a pay-for reporting program that provides a combination of incentives and payment adjustments to eligible professionals and group practices who satisfactorily report data on Physician Quality Reporting System quality measures. The incentive amounts are listed at 0.5 percent for 2012, and at 0.5 percent for 2013 and 2014. We then have payment adjustments beginning in 2015 for this

program. In 2015, the payment adjustment would be 1.5 percent. I just wanted to note that the Physician Quality Reporting System will be the basis for the value-based modifier that's also coming up. This final rule sets forth the requirements for only the 2012 Physician Quality Reporting System. Slide 16 provides a direct link to our Physician Quality Reporting System Web site.

Slide 17 list some of the goals and highlights we considered when finalizing requirements for the 2012 Physician Quality Reporting System. Some of our goals were to encourage participation in the Physician Quality Reporting System. Under that goal, we wanted to streamline the programs that are easier for eligible professionals to report. We wanted to finalize reporting criteria that was consistent with previous years because EPs that have participated previously are already familiar with those reporting requirements. We also wanted to lend permanency to certain program aspects. For example, we are finalizing all three reporting mechanisms—claims, registry, and EHR—for 2012 and beyond. We also wanted you to know that we adopted a core set of measures for the Physician Quality Reporting System and it's pursuant to CMS' Million Hearts Campaign and our goal of preventing cardiovascular disease. Another goal was to align with various CMS quality reporting programs, such as the Medicare Shared Savings Program, the final rule (which just came out), and the EHR Incentive Program.

Some of the highlights for the final requirements under the 2012 Physician Quality Reporting System are as follows:

- We changed the definition of group practice from 2 to 25 eligible professionals.
- We have a plan to post GPRO performance information on our Physician Compare Web site in 2013. There is a link to the Physician Compare Web site on Slide 17 in case you want to check to see if the information was correct.
- We also eliminated the 6-month reporting period with the exception of reporting on measures groups via registry.
- We finalized about 29 additional measures for claims and/or registry-based reporting.

- We have data submission vendors that are able to submit on behalf of the eligible professionals for EHR-based reporting.
- We have adopted all 44 EHR Incentive Program measures for EHR-based reporting.
- We are finalizing eight additional measures groups, which brings us to a total of 22 in this program.
- We have adopted measures that align with the Medicare Shared Savings Program with respect to our measures available for GPRO reporting.
- We are finalizing our proposal to provide interim feedback reports.
- Finally, we finalized a proposal to establish calendar year 2013 as the reporting period for the 2015 Physician Quality Reporting System payment adjustment.

Table 18 provides the criteria for satisfactory reporting on individual measures via claims and registry. As you can see, you would report at least three Physician Quality Reporting System measures, same as last year and in previous years. If less than three applied, you are to report on one to two measures, and you would report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a zero percent performance rate will not be counted. Again, that 12-month reporting period is January 1, 2012 through December 31, 2012.

Slide 19 has our criteria for reporting on individual measures via the EHR. We have two criteria here. One is the criteria on the bottom, which is one we've had in previous years, which is to report at least three measures and to report for at least 80 percent of your patients. Again, measures with a zero performance rate will not be counted. The first criteria above align with the Medicare EHR Incentive Program. We offer the same reporting requirements as the EHR Incentive Program so an eligible professional will report on all three Medicare EHR Incentive Program core measures. If the denominator for one or more of the core measures is zero, you should report up to three Medicare EHR Incentive Program alternate core measures. In addition, you

should report on three additional measures available for the Medicare EHR Incentive Program.

Slide 20 has the criteria for satisfactory reporting on measures groups via claims and registry. Here we actually have a 6-month reporting period, so I wanted to note that. It's from July 1, 2012 through December 31, 2012, and that's set via registry. The reporting criteria are to report on at least one Physician Quality Reporting System measures group, and to report for at least 80 percent of patients. However, the report on each measures group can be no less than eight Medicare Part B FFS patients seen during the reporting period to which the measures group applies. Once again, with respect to all these criteria, measures groups containing a measure with a zero percent performance rate will not be counted.

On slide 21, we have the criteria for satisfactory reporting for group practices participating in the GPRO. As you can see, the reporting mechanism is different from individual eligible professionals. The GPRO report is via a Web interface provided by CMS. There are two reporting criteria here depending on group size. One criteria are related to groups of 25 through 99 eligible professionals, and another criteria for groups of 100 or more eligible professionals. Again, the reporting period is the 12-month reporting period, January 1, 2012 through December 31, 2012.

Moving on to Slide 22 and the measures we have finalized. Just to give you an overview, these are our 2012 Physician Quality Reporting System core measures. The hearts indicate that these measures are consistent with the 2012 Million Hearts ABC measures. We have seven measures here. As you can see, a few of them are prior Physician Quality Reporting System Measures. We have three new measures here. I wanted to note that one of them is only available for reporting via EHR—the Preventive Care and Screening: Cholesterol.

On slide 23, we have our new measures available for claims and/or registry-based reporting. We have listed the total number of measures there.

Slide 24 contains all of our finalized EHR measures. As you can see, we have finalized core measures from the EHR Incentive Program, as well as the alternate core, which are additional EHR Incentive Program measures.

Again, on slide 25, we also have Physician Quality Reporting System EHR measures that are not under the EHR Incentive Program. There are seven of those.

On slide 26, we have a list of our measures available for reporting under the GPROs—a total of 29. Once again, our goal was to try and align some of these measures with the measures finalized in the Medicare Shared Savings Program.

On slide 27, we have a list of our measures groups available for claims and registry-based reporting. On the left side, you see our measures groups that were available for 2011. There are 14 of them. Our new measures groups are on the right side. There are eight: COPD, IBD, sleep apnea, dementia, Parkinson's, hypertension, cardiovascular prevention, and cataracts.

Now, if I can move on to the Medicare EHR Incentive Program and our changes for that program for 2012 Payment Year. On slide 29, we provide you with an overview. The Medicare EHR Incentive Program provides incentive payments to eligible professionals, which are noted as EPs in this program, eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid programs that successfully adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record technology.

In this final rule, we outline the following methods that EPs can use to report CQM, which is a component of achieving meaningful use for the 2012 payment year. One is attestation, which was the method used to report CQM previously.

The EPs may continue to use attestation in order to report CQMs. The second is reporting CQMs via the Physician Quality Reporting System-Medicare EHR Incentive Pilot. This pilot option is intended for those EPs who seek to

earn both a Physician Quality Reporting System and EHR Incentive Program incentives by submitting data on one set of patients. EPs may participate in this pilot by using either a direct EHR or an EHR data submission vendor. On slide 29, we list the Web site for the EHR incentive program. We will provide more information on the pilot on that Web site as well as the Physician Quality Reporting System Web site.

On the last slide, we have noted where you can call an EP or anyone else needing additional help or additional information on the program. We have the Web sites for both the Physician Quality Reporting System and e-Prescribing Incentive Program. We also have our Help Desk contact information for the Physician Quality Reporting System and e-Prescribing Incentive Program. That's at QualityNet Help Desk, and the number is 866-288-8912.

We also have contact information for the EHR Incentive Program. The Web site is posted there, as well as the contact information for the EHR Information Center. That concludes my presentation.

Question and Answer Session

Geanelle Herring: Thank you, Christine. We will now open the line up for Q&A. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the organization you represent. In an effort to get as many questions asked and answered as possible, we ask that you only ask one question. Holly?

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 enter the number of participants currently listening in. If you are the only person in the room, enter 1. If there are between 2 and 8 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 tally the polling results.

Once again, in order to participate in the polling question, if you are the only person in the room, enter 1. If there are between 2 and 8 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. And again, please continue to hold while we poll the results.

Please continue to hold while we poll the results. Thank you. We will now open the lines for a question and answer 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 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 Mary Walton.

Mary Walton: I was listening to everything, but didn't know where to find the presentation. I don't have anything she was looking at. How do I get that?

Diane Stern: It's on the CMS Sponsored Calls page. If you go to the PQRS Web site, on the left-hand side you will see the CMS Sponsored Calls page and that's where you will find the presentation in the Download section.

Christine Estella: Do you have the Web site address?

Mary Walton: The PQRS Web site?

Christine Estella: It's www.cms.gov/PQRS.

Mary Walton: Thank you.

Christine Estella: Thank you.

Operator: The next question comes from the line of Susan Keen.

Susan Keen: I still have some questions in regard to the eRx Incentive Program. We just opted out of all but three of our physicians for 2012 because they didn't meet the criteria. In looking at the documentation you have on page 10, this is what I don't understand, this 6-month timeframe where it says Electronic Prescribing Incentive Program for 2013-2014. It says for the 6 months for claims, report the electronic prescribing measure numerator at least 10 times. I don't get it. What happened to the 25?

Christine Estella: It's 25 or 10 depending on the reporting period. For the 12-month reporting period, if you get the whole year, you report 25 times. If you only have 6 months, then you would report the 10 times.

Susan Keen: So that's a typographical error below it? Because it shows a year-and-a-half.

Daniel Green: Maybe I can clear that up just a little bit. To avoid the payment adjustment in the subsequent year, we need to report 10 times in the first six months of the year.

Susan Keen: Correct, which is why 12 of our physicians say they need to do this.

Daniel Green: Again, for 2011 criteria they had to have 100 visits that appear in the denominator measure, and 10 percent of their charges had to be comprised of those codes that appear in the denominator measure. To avoid the 2012 adjustment they would have to report that to us during the first 6 months on 10 claims, which basically says that they e-prescribed at least one medication during that visit with that patient.

Now to earn an incentive for the year, the eligible professional would have to report that measure 25 times during the course of the year. It could all be in the first 6 months, that's fine, but they have to report in 25 of those G-codes. If they do that, they not only are eligible for an incentive—again, assuming 10 percent of their charges are comprised of codes in the denominator, and also assuming that they are not participating in the Medicare EHR incentive

program for 2011—they would also be precluded from the 2013 payment adjustment. So, that's where the 10 and 25 come into play.

Susan Keen: OK.

Christine Estella: On slide 10, there is a typo. It should be January 1, 2012.

Susan Keen: I was just going to say that I am still confused because it shows an 18-month timeframe there.

Christine Estella: Thanks for bringing that to our attention. We will try and correct that.

Susan Keen: 10 times during that timeframe?

Christine Estella: Yes.

Susan Keen: I know you asked for only one question, but it's all very vague. We had physicians who actually have now reported more than 25 but didn't meet the original criteria of 100. Will they be given an incentive?

Christine Estella: Yes. Are you asking about the 2012 payment adjustment?

Susan Keen: Yes, the original 6 months they had to report 10 in order to qualify, and we had some who did not. However, now those same ones who did not have reported 25, so they are not even being tracked by you. Will they get an incentive if they are reporting?

Christine Estella: The only limitation that applies to the 2011 incentive—and that's what we are talking about because that's the same reporting period for the 2013 payment adjustment—the only criteria limitation that applies to not getting the incentive is, as Dr. Green mentioned, if they get an EHR Program Incentive or if they have less than 10 percent of their targets comprised of codes within the denominator. As long as they don't have any of those limitations for the 2011 incentive, then they would qualify for the 2011 incentive. That's actually all in our Physician Fee Schedule Rule that we published last year for 2011.

Susan Keen: OK.

Daniel Green: Just to be clear, if they didn't report 10 times in the first 6 months, if they didn't have the 100 denominator eligible visits, they would be protected from getting the payment adjustment. If they did have, let's say about 110 of those visits that appear in the denominator of the measure, and they had at least 10 percent of their charges comprised of codes of the denominator, they would be subject to the 2012 payment adjustment. I understand they prescribed more than 25 times for the year. As Christine said, if they are not participating in the Medicare EHR Incentive Program and they have at least 10 percent of their charges comprised of denominator codes, they would be eligible for the incentive. They would get a 1% payment adjustment there, but they would also get a lump sum, a 1% incentive, by virtue of doing the 25 or more e-prescribing events for the whole 12 months, and they would be protected from 2013.

Susan Keen: If they saw 99 patients and didn't hit the 100, but they turned around and prescribed more than 25, they could potentially get an incentive?

Daniel Green: But not the adjustment.

Susan Keen: OK, which is the money taken away. You are calling that the adjustment.

Daniel Green: Well, that's true, I suppose. It sounds better, doesn't it?

Susan Keen: Well, it does, but that's why we applied for the hardship rule on some of our physicians. Thank you very much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Judy Burleson.

Judy Burleson: This is Judy Burleson at the American College of Radiology. Can you give us an idea of when the 2012 measure specifications and the measure applicability validation process document will be posted?

Kimberly Schwartz: November 15th.

Judy Burleson: December 15th?

Kimberly Schwartz: November.

Judy Burleson: OK, thank you.

Kimberly Schwartz: You're welcome.

Operator: Your next question comes from the line of Leah Fisher.

Leah Fisher: This is Leah Fisher from the Azar Eye Institute. We have been with both the PQRS and eRx measures from the beginning and have done fine with them. I am pretty good on all of that until the EHR incentives hit. The EHR incentive is not claims-based. I am the billing manager—so I will not be doing anything with that—but with the eRx that I have been doing, it's my understanding in 2012 that you cannot do the eRx and the EHR incentive both at the same time. If I don't file the eRx measure within that year, because we are doing the EHR incentive, how do you know that in order to not give me the payment adjustment?

Daniel Green: Great question. It's not that you can't do both, it's just that you won't get an incentive payment for both unless you are doing the Medicaid EHR. Then you could get an incentive for the Medicare eRx as well. However, assuming you are doing the Medicare EHR Incentive Program, you are correct; you can't get an incentive in the e-prescribing program as well. So what we would ask is that you do your Medicare EHR incentive and you meet the 15 criteria plus five in all, and you get your incentive. But at the same time, you would want to report to us at least 10 e-prescribing events.

So it might be on some of the same patients that you are actually e-prescribing to meet your meaningful use criteria, but on your claims—just like you've done this past year—you would submit that G8553 that says at least one prescription was generated electronically in a qualified system during this encounter. If you do that at least 10 times in the first 6 months, you will avoid the 2013 payment adjustment. Further, you might even do all 25 and would also avoid the 2014 payment adjustment. In theory, if your doctors could do 25 in the first 6 months, you get out of the 2013 payment adjustment and the 2014 payment adjustment.

Leah Fisher: I thought it was that if we did the eRx for the whole year of 2011.

Daniel Green: You get out of 2013.

Leah Fisher: Right, so 2013 is fine.

Daniel Green: Do 25 during the 12 months of 2012 and you will get out of the 2014, and the program goes away after 2014.

Leah Fisher: If during 2012, I just report the eRx G8553 25 times—

Daniel Green: Per doctor.

Leah Fisher: Per doctor.

Daniel Green: Right.

Leah Fisher: Glad you said that. Now is that for the whole year or within 6 months?

Daniel Green: No, you have whole year if you want to do that.

Leah Fisher: Yes, so it won't be one of the hardships. I saw somewhere that there might be a hardship coming out for that. You are not doing that, but they are just saying to submit it 25 times to cover that end of it?

Daniel Green: The Medicare meaningful use in 2012 will not be one of the hardships.

Christine Estella: No, it will not be.

Leah Fisher: Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Leanne Denissen.

Leanne Denissen: I am sorry. My question has been answered. Thank you.

Daniel Green: Thanks.

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

Leslie Witkin: This is Leslie Witkin at Physicians First. On slide 19, could you just clarify some things for me? For the first EHR reporting mechanism, I understand that you could have a zero denominator for the three EHR core measures, but when you move into the requirement for the alternate core, does the practice have to attest to all three of the core? And if they had a zero denominator for all three of the alternate core, would they then be excluded from participating in this EHR piece for the PQRS bonus?

Daniel Green: Great question. If you are trying to do EHR meaningful use, or the EHR Incentive Program as we call it, one of the criteria is to report Clinical Quality Measures. There are two ways you can do that. You can go into the NLR where you signed up to participate in the meaningful use program, and you can go in and attest to your CQM part. Or if you want to participate in our pilot, you can either submit directly from your EHR, if it's an ONC-certified and PQRS-qualified 2012 EHR; or you can choose one of the data submission vendors and report the information. If you have zeroes in your denominators for your three core measures, then you would have to also report the three alternate cores. Let's say the first two core measures had zeroes but the third one had folks in the denominator. You would have to report two more alternate core measures to get up to your three. Now let's say all three of the core had zeroes, then you would report all three alternate cores.

Leslie Witkin: You have to report all three alternates?

Daniel Green: Right. If they had zeroes as well, you know that for meaningful use you still have to report three more of the remaining 38 measures. CMS would expect you to report the measures that you have to note patients in the denominator. So if you had zeroes conceivably in all 44 of the measures, you could still report that in to us and you would satisfy the meaningful use as well as the PQRS, but you'd actually have to have zeroes for all 44 measures, which we expect would be quite the exception rather than the rule.

Leslie Witkin: You could have zeroes for the three core, you could have zeroes for the three alternate, but you definitely have numerator-denominator for the three CQMs and you would be OK for the EHR and PQRS?

Daniel Green: That's correct. But there's probably somebody that's not going to have any patients in the denominator of the additional 38—and we are speaking nationally here. Again, we expect that to be quite the rare exception.

Leslie Witkin: Right.

Daniel Green: But if you are that person, and you reported zeroes because you are basically saying I had no patient at the denominator of all 44 of these measures, that also would qualify.

Leslie Witkin: If someone wanted to try to do the alignment with EHR incentive and PQRS, and if they are only attesting in 2012 for the first time for 90 days, they would not be eligible for this particular EHR reporting on slide 19. Would you encourage them then to go for that incentive pilot on slide 29?

Daniel Green: Well, you know—

Leslie Witkin: I am trying to get my arms around this.

Daniel Green: It's kind of a large thing to get your arms around. I understand your difficulties; it's a little confusing. In year 1 of meaningful use, we only require a 90-day clinical quality measure reporting period. However, even if you are year 1 in 2012 and you wanted to participate in the pilot, you could still report and collect that information for a year.

Leslie Witkin: Right.

Daniel Green: People would say, "Well, wait a minute, am I not going to delay my meaningful use payment?" The answer to that is yes. If you are going to participate, let's say in the first 3 months of 2012, yes it will delay your payment. But let's say we are going to do the last 3 of the last 4 months of 2012. We are collecting a year's worth of data for PQRS and also for the pilot.

Leslie Witkin: OK.

Daniel Green: So if you weren't really planning to participate in the meaningful use until later in the year anyway, as long as you have your EHR for the entire year and you are using it, the data is already in there.

Leslie Witkin: Right.

Daniel Green: It's not really hard to report. You can report, again, a whole year's worth of data and conceivably get both bonuses. That's the idea. We are trying to reduce duplicative reporting.

Leslie Witkin: I get it. Thank you very much.

Daniel Green: Thank you.

Operator: Your next question comes from the line Jennifer Orandello.

Jennifer Orandello: I hate to make you repeat yourselves, but I just want to make sure that I understand that I am doing this properly. For the eRx reporting, my understanding is that if we participate in a 12-month reporting period, I need 100 denominator eligible cases per physician for the year, and we need to successfully report on 25 per physician. That makes them eligible for the incentive and avoid the payment adjustment. Is that correct?

Christine Estella: Yes, if we are talking about this next year, you would avoid the 2014.

Daniel Green: Let me clarify that just a little bit. If you have fewer than 100 of the denominator eligible visits in the first 6 months, you would not be subject to the following year's payment adjustment. So, if for example you only had 90 9213s or whatever – I am just picking that code out—

Jennifer Orandello: OK.

Daniel Green: You know what the denominator codes for the measures are, presumably.

Jennifer Orandello: Yes.

Daniel Green: So if your doctor, Dr. Jones, only had 90 visits of any of those codes in the first 6 months, he or she would be exempt from the payment adjustment in 2013. Automatically, they would be pulled off the list because we would consider them as not having ample opportunity to report. Now, let's say Dr. Jones only has these 90 visits, but let's say you reported 10 or 12 or maybe even 25 times. Let's say, he or she prescribes almost every time—they're a geriatrician or whatever—we don't require the 100 visits for you to become incentive eligible. One hundred visits is only to keep you out of the payment adjustment if you would be subject to it. You might only have 50 visits, but if you prescribe a prescription every time you see a patient or every other time or what have you, you could still earn the incentive there. The 25 times that you referenced will get you out of the 2014 payment adjustment, not 2013, but 2014. If you do 10 of those 25 in the first 6 months, you will be also out of the 2013 and the 2014 payment adjustments, and you will be able to earn the incentive, provided that 10 percent of your charges are comprised of codes in the denominator and assuming you are not participating in the Medicare EHR Incentive. I know that's confusing and I am sorry.

Jennifer Orandello: Yes, it's a little confusing.

Daniel Green: Maybe we will try to see what we can do specifically focused on e-prescribing. We will see if we can have either a dedicated National Provider Call or some open door forum. We won't even present anything; we will just have people call in.

Jennifer Orandello: Basically trying to get 10 in the first 6 months is really key to a lot of things.

Christine Estella: Right.

Daniel Green: I would tell your doctors every time they prescribe on a Medicare eligible visit—actually for 2012 it's not even tied at the denominator to avoid the penalty—but I would just have them put that G8553 code down every time they e-prescribe on a Medicare patient. That way you should be able to get the 10 in the first 6 months, and hopefully the 25 in the course of the year. It shouldn't be hard again for your primary care-type doctors.

Jennifer Orandello: On the PQRS on slide 18, it's no longer 80 percent of eligible patient encounters; it's now 50 percent on three measures. Is that correct?

Daniel Green: Per claim.

Christine Estella: Yes, per claim.

Jennifer Orandello: Claims-based reporting, yes.

Christine Estella: That was the same with 2011 and 2012.

Jennifer Orandello: Great. Thank you so much.

Christine Estella: No problem.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Sandra Pogones.

Sandra Pogones: This is Sandy Pogones from Primaris. I have a question on one of the statements that was in the regulation. It's regarding how you are classifying a registry as either a registry or an EHR data submission vendor. If a registry pulls data directly from an EHR, will it automatically be considered an EHR data submission vendor and therefore must meet the EHR reporting requirements, or can it choose to remain just a registry?

Daniel Green: If you get your data from an EHR, let's say your ABC vendor that's an EHR also, you would have to apply to be a data submission vendor.

Sandra Pogones: So you can no longer pull your data from EHR and consider yourself a registry?

Daniel Green: Right. We would ask that you become a data submission vendor, which would enable you to report the aggregate. If your system is an ONC-certified system, you could report on their behalf the 3, 3, and 3—the three cores, three alternate cores, plus three. Then in the individual level data in a QRDA, you could actually use the same data. Your doctors would get credit for those programs.

Sandra Pogones: OK, thank you.

Daniel Green: Or, you could just report three measures in a QRDA of the 51 measures that we have and they would qualify for PQRS. Actually then their system doesn't have to be ONC-certified. Just to review, the data submission vendor would have to be PQRS-qualified. You don't have to participate in HITECH and PQRS; you could do PQRS alone, if that's what you choose.

Sandra Pogones: Can I ask one more question or should I wait?

Daniel Green: Go ahead and ask another one.

Sandra Pogones: On page 1078 of the regulation, it states that if an EP chooses to report CQM through attestation and also participate in PQRS Incentive Pilot Program, the file would not need to be placed in a holding status for the CQM objective. It sounds like if you participate in the pilot, you can also report CQM to attestation and then you wouldn't have to wait for your EHR meaningful use incentive payment until the end of the year.

Daniel Green: I believe that is correct. You'd have to be year 1 of meaningful use of 2012 because year 2 of meaningful use, I do believe, has a 1-year CQM time period. If you were year 1, I believe that is correct. Does anybody know for sure?

Aucha Prachanronarong: I believe you are correct, yes.

Daniel Green: OK, thanks. So we are all in agreement here. We believe that to be the case.

Sandra Pogones: Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Sheila Rolando

Sheila Rolando: My question is are we required to participate in this incentive program? Our agency is small, with only six professionals. I am noticing everything is from 25 to 99 or over.

Christine Estella: That would be with respect to group practices that elect to participate in a group practice reporting option; that's our GPRO. There are two ways an eligible professional can participate. One is an individual eligible professional and the second is as a group practice within the GPRO. But even if your practice has six doctors, you would still be eligible as a professional to participate in the various programs we have.

Sheila Rolando: My next question is regarding the hardship exemption. As we are small, we do not have the capability at this time for electronic prescribing.

Daniel Green: Not having an electronic prescribing system itself is not an acceptable hardship for us. If you don't have high-speed Internet in your practice area, if you don't have ample pharmacies that can accept prescriptions electronically, if you are already registered with the meaningful use for 2011 and have an ONC-certified system, these are examples, among others, of acceptable hardships for 2011. Simply not having the system and/or having a small group, or the system is expensive, while very valid concerns for an individual group, is not one of the hardship exemptions we approve.

Sheila Rolando: So our professionals are required to participate in this program?

Daniel Green: Again, the question you asked earlier about how you're less than 25 was typically related to PQRS, although it can relate to e-prescribing. The program we are talking about is the electronic prescribing program. Again, we don't actually "require" you to participate in it. But folks that don't participate and don't have an acceptable hardship would be subject to the payment adjustments starting January 1, 2012, which means all their charges that come in for dates of service after January 1, 2012 would be reduced by 1%.

Sheila Rolando: Thank you.

Daniel Green: Thank you.

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

Nancy Mullins: I represent a therapy group which has PT, OT, and Speech and we've been doing the PQRI, then S, systems since 2007. When I go to page 18 and see the

claims reporting, I understand that part perfectly. Our system is a multi-group physician practice that is qualifying for the EHR incentive. Therapists do not have that option even though we do convey our measures by EHR. So, on page 19, does the second option EHR—even though we don't get any money from meaningful use—do we fall into that bracket, or do we stay in the page 18 where it's 50 percent of all the measures to be reported?

Christine Estella: I guess it would depend on your reporting mechanism. Slide 18 has our reporting criteria for the claims and registry. Slide 19 has our criteria for the EHR- based reporting mechanism. For the second criteria on slide 19 for EHR recording, you would need to report via a qualified direct EHR or qualified EHR data submission vendor.

Nancy Mullins: That's what we have been doing for the last two years. We do have a certified EHR. We are submitting our claims measures through EHR. We don't have the measure for at least 50 percent. We go to the 80 percent like it started out initially?

Daniel Green: I want to make sure I understand your question completely. I understand you capture your information in an electronic health record. Is that correct?

Nancy Mullins: That's correct.

Daniel Green: How do you report the information to CMS? Are you using a registry? Are you reporting directly from an EHR? Are you reporting on claims, but the claims are sent electronically?

Nancy Mullins: The third. Claims, and they are sent electronically.

Daniel Green: OK. So your reporting threshold would be 50 percent.

Nancy Mullins: That's what I needed to know. I appreciate that.

Daniel Green: Even though it's coming from an EHR, you construe that as claims reporting. Thank you.

Nancy Mullins: Thank you very much.

Operator: Your next question comes from the line of Tomeka Barnes.

Tomeka Barnes: I am calling from Wayne State University Physician Group Department of Neurosurgery. I am confused on the measurement number 20 and measurement number 22. The measurement number 20 is "document the order of a prolactin to be given within one hour of the surgical incision." And the 404-6 is stating "document the prolactin that was given within four hours prior to the incision." Originally we were doing the 404-9 for the discontinue; however, they said you have to pair it with the 404-6.

Daniel Green: Hang on half a second.

Christine Estella: Are you referring to the Physician Quality Reporting System number?

Tomeka Barnes: Yes.

Daniel Green: Give us one second.

Kris Peters-Help Desk: This is Kris. I would like to have a chance to look at the measures. Can we get your name and contact information, your number, and call you back? I will give you a call and we can discuss the measures.

Tomeka Barnes: OK.

Operator: Your next question comes from the line of Tracey Kartsone.

Tracey Kartsone: This is Tracey. I have a question with regard to the exemption for the e-prescribe. I am wondering who is authorized to file for that exemption for a provider that does qualify?

Christine Estella: For anyone who didn't hear, she was asking who was authorized to file a request for a significant hardship exemption. I am assuming that's with respect to the 2013 and 2014 payment adjustment.

Tracey Kartsone: Yes.

Christine Estella: For the 2012 payment adjustment, we finalized in a standalone rule that only EPs would be allowed to submit requests for significant hardship exemptions

for the 2012 payment adjustment. For the 2013 and 2014 payment adjustment, we've changed that. Basically, a person authorized to legally act on behalf of the eligible professional would be able to submit a request for a significant hardship exemption for that eligible professional for the 2013 and 2014 payment adjustments.

Tracey Kartsone: OK, because I received a generic letter that doesn't address the doctor's name, because I thought I filed that exemption. I am the billing manager, and I received a letter that said specifically billing managers can't do that.

Christine Estella: Right. That's with respect to the 2012 payment adjustment that's coming up, but we've changed that for the 2013 and 2014 payment adjustments. For the 2012 payment adjustment, which is what that letter refers to, an eligible professional himself would have to log in to the Communication Support page and submit that request directly.

Tracey Kartsone: OK, thank you.

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

Jennifer Montgomery: This is Jennifer Montgomery from Beth Israel Medical Center. Thank you for taking my call. I am a little confused now with the 6-month and 12-month reporting periods on page 10. The 12-month reporting period is done with the denominator codes. The 6-month reporting periods, I believe somebody said, don't need the denominator code.

Christine Estella: Yes, that's correct. For the 12-month reporting period, the criteria are the same as the incentive. For the 2014 payment adjustment, the criteria within that for the 12-month reporting period, is the same as the 2012 incentive. So for the 2012 incentive you needed to report the numerator with a visit associated with the denominator.

Jennifer Montgomery: Got that.

Christine Estella: Then the 6-month payment adjustment reporting period for 2014—that's only to get out of the payment adjustment. So you would report 10 times.

Regardless of whether or not a visit is associated with the measures denominator, you would report the numerator code G8553.

Jennifer Montgomery: So if I am surgeon and I do a surgery—

Daniel Green: Yes, that's the whole idea. What we are trying to do here is to broaden. We are trying to make sure people who are e-prescribing are not being penalized inadvertently. We recognize that surgeons, for instance, that their postop visit is not a billable charge but it is still sent in. Let's say the patient has a wound infection and you e-prescribe an antibiotic. We are happy that the doctor is utilizing e-prescribing. In the end, that is what we are trying to encourage. We don't want that doctor to get penalized because of a technicality in the law. We are counting that prescription if you send it in with a G8553 as one of the 10 required in the first 6 months to avoid the payment adjustment.

** Please note, the information given during the call was incorrectly stated. Below is the correct information:

"When a medication is prescribed electronically using a system that meets the requirements of the measure, the EP can report it to CMS on a claim containing any billable code--not just the codes in the denominator of the measure. This rule applies for an EP trying to collect the 10 required eRxs to avoid the payment adjustment. Physicians and practitioners should continue to follow established payment rules. For instance, physicians and practitioners should not bill for services that are included in the global surgical period, such as follow-up visits and services, as Medicare's global surgical payment already includes payment for those services. To earn an incentive, an EP must report the eRx event for an encounter as defined in the denominator of the eRx measure."

Jennifer Montgomery: OK.

Daniel Green: However, to earn the incentive, we are forced to go back to the codes that are in the denominator of the measure. We are trying to prevent folks from getting this adjustment.

Jennifer Montgomery: Right. I hate to ask, but I have one other question and I am not sure this is the forum to ask. If it's not, you can direct me to whom I can ask. We are starting to get a lot of incentive payments, and PQRI and e-prescribe are very well broken out. We have no problem divvying them up, but we are getting all kinds of PCIP and other incentive payments. It's kind of becoming a nightmare because the EOBs that come with the group NPI are breaking down the doctor's NPI on this detail sheet, but they are scattered through the pages.

Is there someone we can ask about possibly getting that information at least to link together? Who would I ask?

Louisa Rink: You can contact your carrier. We've had that comment from a lot of physicians. The folks who are in charge of those programs are making changes to break out the NPIs in a similar fashion on your HPSA and PCIP and general surgery bonuses. I am not on that team, but I think that would be for the April payment, but your carrier or MAC will be able to give you the answer to that.

Jennifer Montgomery: Wonderful. Thank you very, very much.

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

Joanne Warren: I'm Joanne Warren from Dalton Medical. I had a problem receiving money last year for the eRx. I didn't put the penny in and so they encouraged me to do the PQRS. The Quality Help Desk walked me through it. We did it together for last year's diabetic measure and I did not get incentive payments. I had trouble getting reports. I got one doctor's report. The others, I guess, there is a whole problem with the reporting system. Because of the problem with the reporting system, does it also affect the payment? I didn't have access until after November 2nd. I did send another request because I see reports are now available. I was told when they walked me through it that we had to do 25 patients for that diabetic group measure. Now from what I can see, it was 80 percent.

Daniel Green: I think maybe there's a little confusion. For the diabetes measure set, if you will, we call that a measures group.

Joanne Warren: Right.

Daniel Green : We require that all the measures that are in the group be reported on 30 patients.

Joanne Warren: Correct.

Daniel Green: The other option to that is if you are reporting for a year. Let's say you don't have 30 patients, you could report on 80 percent or—are you reporting by claims or registry?

Joanne Warren: Claims.

Aucha Prachanronarong And are you referring to program year 2010?

Joanne Warren: Correct. For payment this year.

Daniel Green: Again, if you are reporting the measures group in 2010 you can report on the 30 patients, or 80 percent of your patients that would meet the denominator of the measures group, with the minimum of 15 for a 1-year reporting period or a minimum of 8 patients for a 6-month reporting period. That's probably where you read the 80 percent, and I am not sure why they told you 25, because the number is 30. Again, 25 is in our e-prescribing program.

Joanne Warren: OK, so 30 of them. One of my reports—like I said, they didn't have them available on the other physicians though I did them all the same—was at 53 percent for the reporting rate; the numerator was only 24 for this particular physician.

Daniel Green: Did you call the Help Desk about this?

Joanne Warren: I have and they sent me these reports. My biggest fear is that there is no way to confirm you have that data until next year. So you may think you are doing it correctly. I know that I reported more than 30 patients for each physician, but according to this report I received there are only 24 for this one particular doctor.

Daniel Green: OK, what we will do is have the Help Desk reach out to you and try to discuss it.

Joanne Warren: No, it's supposed to go up to another level, but it hasn't. That was like two or three weeks ago.

Daniel Green: Just two other points real quick. Remember, a measures group is usually four or more measures.

Joanne Warren: Right.

Daniel Green: I think diabetes is five or six.

Joanne Warren: Yes, we did that.

Daniel Green: You have to report on those 30 patients all six of those measures, or however many there are.

Joanne Warren: Correct.

Daniel Green: The other thing, and not to excuse anything, but I will say that our Help Desk has been just a little bit unusually swamped the past 3 to 4 weeks because of this hardship exemption that folks are trying to get in. The length of time to get into the Help Desk has been unusually long for us. I think they probably get tied up more with that because it's time-dependent. That may be why you haven't gotten up to the next level. But if you want, is somebody from the Help Desk on the call?

Kim Sullivan: Yes we are here.

Daniel Green: Would you please take this person's contact information and follow up with them?

Kim Sullivan: Yes.

Joanne Warren: So for this year, to report on a measure, if you do individual measures, how many do you need to report? Fifty percent for claims?

Daniel Green: That's correct. If you are doing three measures, you have to report on 50 percent of the eligible patients per doctor for the year. So if Doctor A sees 100 diabetic patients, you have to report the measures on 50 patients.

Joanne Warren: And the patient's only counted once. Correct?

Daniel Green: It depends on the measures. If you're doing the diabetes, then those are once per reporting period.

Joanne Warren: OK.

Daniel Green: If you were doing pneumonia, for example, that's once per episode, because you can imagine that would you need to do the quality action each time the patient comes down with a new diagnosis of pneumonia.

Joanne Warren: Correct.

Daniel Green: If they get it more than once a year.

Joanne Warren: OK, thank you.

Operator: Your next question comes from the line of Janet Meives.

Janet Meives: This is Janet Meives with Missouri Cardiovascular Specialists. I have a question in regard to e-prescribing. I have an eligible professional who joined our group in September, which gives him a new Tax ID number. It's my understanding that he would not get a 2012 reduction because he was not part of this Tax ID number in the first 6 months of 2011.

Daniel Green: You are absolutely correct. Your new doctor would not be subject to the payment adjustment for 2012.

Janet Meives: Then under the Tax ID number he had in September, and the one he will have for 2012, he needs to get 10 e-prescriptions to not have a reduction in 2013, and he will have to get those 10 in the first 6 months. And he would have to have 25 e-prescriptions in 2012 over the 12-month period to not have a reduction in 2014.

Daniel Green: That is correct.

Janet Meives: I just wanted to make sure I had my head around it correctly. Can I have one more question? You brought something up that I haven't heard earlier.

Daniel Green: Since you had an easy question, we will let you have another one.

Janet Meives: I also have some surgeons and I didn't know that we could turn in the e-prescribing code with a global no-charge visit to keep them from having the reduction.

Daniel Green: That's in 2012. That's not for this year; that's for the upcoming year.

Janet Meives: It will help me with my 2013 because it's only the first 6 months, correct?

Daniel Green: Correct.

Janet Meives: So I have to work with my practice management system that doesn't send zero claims to get this sense so that the e-prescribing can go with it.

Christine Estella: Right.

Daniel Green: Yes, that would be a good thing, but remember to attach a penny to it, if you can.

Janet Meives: OK, so I could change my postop visit to a penny and have it written off?

Daniel Green: That's right.

Janet Meives: Thank you very much. I appreciate it. That was something I have been struggling with and had never gotten that little nugget of information. So thank you very much.

Daniel Green: Glad we could help. One last thing before you run though.

Janet Meives: Yes.

Daniel Green: One thing you can do to double check, if you will, is that when you send that claim in you should get an M365 code back.

Janet Meives: Correct.

Daniel Green: That will tell you we have received it.

Janet Meives: I knew we were doing it on the ones where they actually had visits. This will be a new thing to send it in with one where it is just the no-charge global postop visit so thank you very much.

Daniel Green: Thank you.

Geanelle Herring: Holly, we have time for just one more question.

Operator: OK. Your final question comes from the line of Heidi Harting.

Heidi Harting: This is Heidi Harting from Summit Medical. I am going to ask a Part A, Part B, if I could squeeze that in real quick. For Part A, I just wanted to confirm that data for the PQRS meaningful use EHR incentive overlap; a data submission vendor would be a current PQRS data submission vendor. That's what that would be referring to?

Daniel Green: No. Quite honestly we don't have any qualified data submission vendors because this is a new concept.

Heidi Harting: OK.

Daniel Green: We will be vetting those who self-nominate in the first few months of 2012. You could look, and again this is no guarantee, but you could look at the EHRs that were qualified for 2011. Also look at those that were also registries in 2011. They will have essentially met most of the requirements. I would expect they will self-nominate for data submission vendors, but that's only my guess; that's not an absolute. We have to ultimately wait and see that they do self-nominate.

Heidi Harting: So registries for PQRS in 2011—we should go to them and say, "Hey, you were for 2011. Are you going to be self-nominating for 2012?"

Daniel Green: But 2012 as a data submission vendor. Are you using an EHR in your practice?

Heidi Harting: Yes, we have been for years, and we have been using a vendor to submit registry for us.

Daniel Green: Do you mind me asking which EHR you use?

Heidi Harting: Not at all. Allscripts Enterprise.

Daniel Green: Allscripts is a registry with us. I am not sure they are a qualified EHR.

Heidi Harting: They are at a certain level.

Daniel Green: OK, so you would need to double check with them as to whether or not they are planning to become a data submission vendor. If they are, and you are intending to report meaningful use and PQRS, you could report one data to the data submission vendor and they could report in both ways if they become qualified on your behalf.

Heidi Harting: My Part B on that question is real quick. When you mentioned the self-nominated for pilot, that would be the data submission vendors or is that us as a medical group saying we want to participate and submit?

Daniel Green: That would be the data submission vendor. If you are using a qualified EHR and you want to submit directly from your EHR for each of your docs—if your system is ONC-certified and then becomes PQRS-qualified—let's say for 2012, you could submit using the HITECH criteria, the three core and/or three alternate core plus three measures directly in by getting an IACS account. But by directly submitting it into the PQRS portal, you can conceivably get both incentives. Let me back up. You could meet the CQM, this clinical quality measure requirement of HITECH; you would still have to do the other 14 things, or whatever they require. But you'd meet this CQM part for them and you'd meet the PQRS requirement as well.

Heidi Harting: Thank you.

Daniel Green: Thanks.

Geanelle Herring: Thank you. I would like to thank everyone for joining us here today, and your participation in the question and answer portion of the call. The audio file and transcript will be made available shortly at http://www.cms.gov/pqrs on the

CMS Web site. If you were unable to ask a question to CMS subject-matter experts gathered here today, please feel free to contact the QualityNet Help Desk at 866-288-8912. Thank you everyone and have a wonderful evening.

Operator: Thank you for participating in today's Physician Quality Reporting System and Electronic Prescribing National Provider Call. You may now disconnect.

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