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

Operator: At this time, I would like to welcome everyone to today's "Physician Quality Reporting System and Electronic Prescribing Incentive Program" National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Charlie Eleftheriou.

Announcements and Introduction

Charlie Eleftheriou: Thank you. Hello. And as Holly mentioned, this is Charlie Eleftheriou from the Provider Communications Group here at CMS and I'll serve as your moderator today.

I'd like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing Incentive Program National Provider Call. Today's National Provider Call is part of the Medicare learning network, your source for official CMS information for Medicare fee-for-service providers.

Today's presentation will provide an overview of the 2013 Medicare Physician's Schedule – I'm sorry, Physician Fee Schedule Final Rule. The presentation will be followed by a question-and-answer session, giving participants an opportunity to provide input and ask questions related to the topic.

Before we get started, there are a few items I'd like to cover. There is a slide presentation for this session. A link to the presentation in today's – I'm sorry, a link to the presentation only was e-mailed to all registrants just after 1 p.m. today. If you did not receive the e-mail, please check your spam or junk mail folders for an e-mail from CMS National Provider Calls.

Also, the presentation can be found by visiting cms.gov/npc. That's N as in "national," P as in "provider," C as in "call," and then clicking on the National Provider Calls and Events' link on the left side navigation panel and then finding today's call by date on the list. Also, the announcements for today's presentation are available on that page.

Next, a reminder that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Physical Quality Reporting and National Provider Call's Web pages on the CMS Web site.

We'd like to thank those of you who have submitted questions when registering. Your questions were shared with the speakers to help prepare for this and future calls. And lastly, please note

that all pertinent resources and contact information related to today's call are available on slides 41 and 42 of today's presentation.

And with that said, I will now turn the call over to today's presenter, Christine Estella.

Presentation

Christine Estella: Thanks, Charlie. Just a quick note, slide three provides you with our agenda and it says on the top there are CMS updates and announcements. We do have some announcements that was sent – that were also sent out along with the presentation. We're not going to go over them at this time. So right now we're going to move straight into our presentation.

So as we move to slide five, we're going to discuss the Physician Fee Schedule Final Rule that was published November – it was displayed November 1 and it was published this past Friday, November 16. So this is going to provide you with updates on the quality reporting components that were provided in the Physician Fee Schedule Final Rule.

On slide six, we have our PQRS goals. What are CMS' goals with PQRS and to what extent have we achieved these goals? In our proposed rule – in our discussion related to the proposed rule – we provided the public with goals that we considered while establishing proposals and, later on, requirements for PQRS.

One of these, as noted on slide six, is to align with other Medicare quality reporting programs that have quality reporting measure requirements, such as the EHR Incentive Program, the Medicare Shared Savings Program, and the Value-Based Payment Modifier.

A second goal for PQRS is to increase participation to 50 percent by calendar year 2015. This will be the first year that PQRS will not offer any incentive. Traditionally, we offer incentives for satisfactory reporting. Starting in 2015, we will only offer payment adjustments for non-satisfactory reporting of PQRS quality measures.

Third, we wanted to – due to the fact that, in 2015, no other incentives would be offered and only payment adjustment would be provided, we wanted to ease eligible professionals into reporting for PQRS, especially those who are reporting for the first time. So we proposed an alternative means to avoid the 2015 and 2016 PQRS payment adjustment that were different from our proposals for the criteria to meet the 2013 and 2014 PQRS incentive.

And, lastly, we've stressed the importance of PQRS being viewed not simply as a program that adds administrative burden, but rather, a program that collects meaningful data that facilitates the overall improvement in quality of care.

On slide seven, we have a couple of updates in terms of our alignment efforts with PQRS and the EHR Incentive Program. So the first one is, we did finalize the extension of PQRS Medicare EHR Incentive Pilot into 2013. The pilot was established last year in 2012. And it's basically a way that EPs that are using EHRs that are both CEHRT and qualified EHRs under PQRS to report ones that have data to satisfy, satisfactory reporting for PQRS for the 2013 incentive, as well as satisfy the CQM component of achieving meaningful use in 2013.

Additionally, under the second sub-bullet, we have alignment satisfactory reporting criteria for 2014 – for the 2014 PQRS incentive, using the EHR-based reporting mechanism with the criteria for meeting the CQM component of achieving meaningful use under the EHR Incentive Program. So, basically, starting in 2014, the criteria for using an EHR to report satisfactorily under PQRS, as well as meet the CQM component under the EHR Incentive Program, would be aligned.

Third, in PQRS, we are finalizing a consideration, actually, that we would require that EPs using an HER, that the EHR would be certified by ONC, so it would be designated as Certified Electronic Health Record Technology, or CEHRT.

Initially, we had proposed basically that the – we would discontinue the qualification process for EHRs. We'd also consider that, in lieu of that, we would require CEHRT. So we actually did finalize our consideration that we are requiring, starting in 2014, that eligible professionals and group practice use CEHRT to report PQRS measures.

On slide nine, we have our – we have outlined our alignment efforts that we have achieved between the PQRS Group Practice Reporting Option, or GPRO, and the Medicare Shared Saving Program.

The first bullet is our GPRO measures. We actually have aligned the measures available under the PQRS GPRO with the measures available under the Medicare Shared Savings Program. So the GPRO measures now contain a set of 18 measures, 2 of which are composite measures.

The Medicare Shared Saving Program has a total of 22 measures. There is, I guess, a little discrepancy in terms of the number. But the actual set of measures is the same. It's just that we count two of the measures as composite, as a whole, whereas under the Medicare Shared Savings Program, they count the composite measures under separate – as separate measures.

Also, under the second bullet, Accountable Care Organizations in the Medicare Shared Savings Program can also participate in PQRS using the PQRS group practice reporting option.

Now, this was actually established for the Medicare Shared Savings Program Final Rule. And it basically provided a way for ACOs to participate in PQRS under the GPRO. Under that mechanism – under that reporting option, basically, an ACO would use the GPRO Web interface to report PQRS quality measures.

Third, we finalized the adoption of the Medicare Shared Savings Program method of assignment and sampling. Initially, we had used – PQRS had used an assignment and sampling methodology that was slightly different from the Medicare Shared Savings Program.

Both methods were both based off of our physician group practice demonstration, or PGP demonstration. But, however, the Medicare Shared Savings program assignment and sampling methodology has a focus of more towards primary care, and requires that, I believe, that there be at least one primary care visit. We are adopting under PQRS the assignment and sampling methodology of the Medicare Shared Savings program.

In addition, under the fourth sub-bullet, under the Medicare Shared Savings Program, ACOs successfully reporting measures under the Medicare Shared Savings Program via the GPRO Web interface will not be subject to the PQRS payment adjustment as long as the ACOs satisfactorily report at least one measure.

So, basically, under the Medicare shared savings final rule, the final rule provided for ways that an ACO could earn a PQRS incentive for participating in PQRS under the GRPO. However, it did not address the issue of payment adjustment. So in this Physician Fee Schedule Final Rule, we actually addressed the issue of what would happen with the ACOs who are reporting under the GPRO with respect to the PQRS payment adjustment.

So we've finalized, basically, that the GPROs would have the same criteria for the PQRS payment adjustment as the regular GPROs do, which would be, if you reported at least one measure, you would avoid the 2015 PQRS payment adjustment.

On slide nine, we have our alignment efforts outlined between PQRS and the value-based payment modifier. So the first bullet, the value-based payment modifier and meeting the criteria for satisfactory reporting for the 2013 PQRS incentive and 2015 PQRS payment adjustment.

Basically, under the final rule, the value-based payment modifier, whether or not – would – an EP or group – actually, a group practice that consists of 100 or more eligible professionals would

not be subject to the value-based payment modifier in 2015 if the group reports satisfactorily for the 2013 PQRS incentive.

Under the second sub-bullet, a group practice consisting of 100 or more eligible professionals beginning in 2013 will be subject to the value-based payment modifier. That was actually finalized in this year's final rule.

A group practice with 100 or more of eligible professionals may avoid a 2015 VBM downward payment adjustment by satisfactorily reporting to avoid the 2015 PQRS payment adjustment. And that's outlined later in slide 23.

And another note, the 2015 and 2016 value-based payment modifier does not apply to ACOs. So any of you ACOs participating in the GPRO, the VBM does not apply to you.

On slide 10, we have a summary of changes to PQRS. First, I'm going to summarize the reporting period. So for the 2015 and 2016 PQRS payment adjustment – we had finalized a 12-month reporting period and we're adding a 6-month reporting period, basically because it coincides with the reporting periods for the 2013 and 2014 PQRS payment – PQRS incentive.

For 2017 and subsequent years, we finalized our proposal to adopt the 12-month reporting period only.

Slide 10 on the bottom also provides the different incentive and payment adjustment amounts. So for 2013 and 2014, we have an incentive amount of 0.5 percent. So as you can see, the PQRS incentive ends in 2014.

Starting in 2015, we begin our payment adjustment. So in 2015, there is a payment adjustment of 1.5 percent and then it increases to 2 percent for 2016 and subsequent years.

On slide 11, reporting mechanisms. So for registry, we expanded the use of the registry-based reporting mechanism to group practices participating in the GPRO. In prior years, or last year actually, registry is only available for EP individual reporting. And so now we're extending this to reporting for groups.

For the EHR-based reporting mechanism, beginning in 2014, all direct EHR products and EHR data submission vendors' products must be certified and classified as CEHRT. Also, we are expanding this to the EHR-based reporting mechanism to group practices in the GPRO, and that's beginning in 2014.

We initially proposed the start – use of the EHR-based reporting mechanism for groups in 2013. We're delaying this expansion to 2014 mainly to coincide with the EHR Incentive Program because their group practice option won't start until 2014.

For the GPRO Web interface, as I mentioned earlier, we have adopted the Medicare Shared Savings Program method of assignment and sampling.

And this is an FYI. For regular claims, we had proposed to expand the use of the claims – traditional claims-based reporting mechanism to group practices. We did not finalize that proposal.

Moving on administrative claims, this is a reporting mechanism under which an eligible professional or group practice elects to have CMS analyze claims data to determine which measures an eligible professional or group practice reports. So basically, with the administrative claims, this is different from the traditional claims-based reporting option, in that a traditional claims-based reporting option, you have to submit reporting G codes on claims. Under this, CMS would perform the analysis. So no reporting of G codes would be necessary.

We finalized this administrative claims option and reporting mechanism for the 2015 PQRS payment adjustment only. We initially proposed to extend this reporting mechanism to the 2016 PQRS payment adjustment. We only finalized it for the 2015 payment adjustment and we will revisit whether or not to include this reporting mechanism for the 2016 payment adjustment in future rulemaking.

Under this reporting mechanism, eligible professionals and group practices need to complete this election by – actually, October 15, 2013.

So basically, with the administrative claims-based reporting option, if you want to use this for the payment adjustment, and it's only available for the payment adjustment, you would actually have to affirmatively elect to be analyzed under the administrative claims-based reporting option, and you would have to make that election by October 15, 2013.

On slide 12, we have our discussion on PQRS reporting as an individual eligible professional. Benefits of participating as an individual eligible professional. First, there is no requirement to register or participate as an individual. And the one exception was the exception that I noted previously, was that if you wanted to use admin claims to report for the 2015 payment adjustment, you would have to affirmatively elect the admin claims-based reporting option. For eligible professionals in solo practices, participating in PQRS as an individual is the only option for you.

And also under the third bullet, eligible professionals within your group practice may freely choose which PQRS measures to report. There are currently – there are slides later that provide descriptions on the number of measures available, but I believe there's a little bit under 300 measures available, and they range in varying topics and they address a broad array of specialties. So if you're reporting as an individual, and usually these measures are available for individual reporting, you can kind of pick which measures under which you want to report for PQRS.

Slide 13, how to participate as an individual. Choose a reporting period, reporting mechanism, and reporting criteria. So, as I noted earlier, there are two available reporting periods. There's a 6- and 12-month reporting period.

There are available reporting mechanisms: the claims, registry, EHR, and admin claims. The only reporting mechanism you don't have available to you when you're reporting as an individual is the GPRO Web interface.

You would choose the individual measures or measures groups you wish to report and then you would start reporting, so you wouldn't need to register to report PQRS. You could just start reporting.

Under slide 14 and 15, we have the actual criteria that we finalized for satisfactory reporting for individual EPs for the 2013 and 2014 PQRS incentive. They're largely the same as the criteria that we finalized for 2012.

A couple of things of note, however. For example, for reporting for the 2013 and 2014 PQRS incentive using measures groups, using claims and registry, we lowered the number of minimum patients on which to report on, so incentive reporting on at least 30 Medicare Part B FFS patients.

For claims, we are – we lowered that down to 20. So, for claims, you would only have to report on 20 Medicare Part B FFS patients.

For reporting via registry, you would report only 20 patients, a majority of which much be Medicare Part B FFS patients, the majority is 11. To the extent that you report on, let's say, more than 20 patients – if you report on 30 patients, it would – it would still suffice that you're reporting at least 11 patients.

In addition, on slide 15, we have reporting for the PQRS incentive – 2014 PQRS incentive, and I wanted to note that we, for the EHR-based reporting mechanism, we have adopted the criteria for meeting the CQM component of achieving meaningful use in 2014. So for 2014 the criteria

would be to report nine measures covering at least three domains. And that's under the fourth and fifth row on slide 15.

So reporting using a direct EHR product at a CEHRT, and reporting using an EHR data submission vendor's product at a CEHRT.

On slide 16, we discussed reporting as an individual for the PQRS payment adjustment. On slide 16, we have the payment adjustment amount. It was also previously indicated in the previous slide.

On slide 17, there are three ways an individual eligible professional may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment. The first way is to meet the criteria for satisfactory reporting for the 2013 PQRS incentive. So it was the criteria specified on slide 14.

The second is to report one valid measure or measures groups using the claims, registry, or EHR-based reporting mechanism. So that's the lower criteria for the payment adjustment.

Third is to elect to be analyzed under the administrative claims-based reporting mechanism. Please note that if you're participating in PQRS through another CMS program, such as a Medicare Shared Savings Program, please check the programs requirements for information on how to simultaneously report under PQRS in the respective program, if applicable.

There is one way an eligible professional may meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment. And that only criteria is to meet the criteria for satisfactory reporting for the 2014 PQRS incentive, and that's on slide 15.

We've proposed additionally to – options two and three for the 2016 PQRS payment adjustment as well. However, as I noted earlier, we're going to assess in future rulemaking whether or not we should have a lower criteria for reporting for the 2016 PQRS payment adjustment; if so, what it should be. And we will also address in future rulemaking whether or not we would have the administrative claims-based reporting mechanism available for the 2016 PQRS payment adjustment.

On slide 18, we have PQRS reporting as a group practice as opposed to individual. So the benefits of participating as a group practice – billing and reporting staff may report one set of quality measures data on behalf of all eligible professionals within a group practice, reducing the need to keep track of eligible professionals' reporting efforts separately.

How to participate as a group practice. First, you would have to meet the definition of a PQRS group practice. We had actually changed the definition of a PQRS group practice in this final rule.

As proposed, we have lowered the minimum amount to two. So, basically, a group practice is now defined as a single TIN with two or more EPs as opposed to 25 or more EPs. So, basically, what we have done is we have incorporated groups of 2 to 24 eligible professionals into the GPRO, so these smaller groups can now participate in the GPRO starting in 2013.

Second, under slide 19, in order to participate in the GPRO, a group practice would have to self-nominate to participate in the PQRS group practice reporting option for that year.

Slide – or option two provides information on how to self-nominate as well as the deadline. As you know – as indicated on slide 19, the deadline of self-nominating for the GPRO has been extended to October 15, 2013. In prior years, the self-nomination deadline was January 31.

However, because we're opening up new reporting mechanisms, we thought it appropriate to extend the self-nomination period to October 15, 2013. However, because we have extended this self-nomination period – we used to have an opt-out period, whereas, if after January 13, we used to have until April to opt out of participating in the GPRO. Now, you don't have that opt-out period. So basically if you self-nominate, that means that you are participating in PQRS using the GPRO.

Number three, choose a reporting mechanism and reporting criterion. So the available reporting mechanisms for 2013 are the GPRO Web interface and registry, as well as admin claims for the 2015 PQRS payment adjustment.

Please note though, if you are a small group of two to 24 EPs, the only reporting mechanisms that would be available to you for the incentive would be the registry-based reporting mechanism, mainly because the GPRO Web interface is only available to groups that has 25 EPs or more.

Beginning in 2014, the EHR-based reporting mechanism will also be available for use under the GPRO. And after you're chosen a reporting mechanism and reporting criterion, you could just start reporting.

Note that if you are a group practice consisting of 100 or more eligible professionals, beginning in 2013, you will be subject to the value-based payment modifier. More information on the value-based payment modifier will actually be discussed in a subsequent National Provider Call on the 28th.

On slide 20, we have the criteria for satisfactory reporting of data on PQRS quality measures using the GPRO for the 2013 incentive. And on slide 21, we have the criteria for the 2014 incentive.

So, basically, the criteria of using the GPRO Web interface would remain the same as in previous – as last year and this year. For the registry-based reporting mechanism, as well as the EHR-based reporting mechanisms that we introduced, the criteria would be similar to the individual reporting criteria that I discussed previously, I believe they're in slide 15 and 16 – or, yes – or 14 and 15, sorry.

On slide 22, we have reporting as a group practice, the PQRS payment adjustment. On slide 22 we have the payment adjustment amount which I discussed earlier.

On slide 23, there are three ways a group practice may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment. First, meet the criteria for satisfactory reporting for the 2013 PQRS incentive under the GPRO; two, report one valid measure or measures group using the registry or GPRO Web interface reporting mechanism; or three, elect to be analyzed under the administrative claims-based reporting mechanism.

This election to choose the self – the administrative claims-based reporting mechanism will be made when the group practice self-nominates to participate in PQRS under the GPRO.

Note that ACOs participating in the Medicare Shared Savings Program may only choose options one or two to meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment. ACOs in the Medicare Shared Savings Program may not elect the administrative claims-based reporting mechanism.

And under slide 24, there is one way a group practice may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment, and that is to meet the criteria for satisfactory reporting for the 2014 PQRS incentive under the GPRO. And as noted, for individual reporting, we will consider other alternatives to reporting for the 2016 PQRS payment adjustment in future rulemaking.

On slide 25, we begin our discussion on our PQRS measures. As I noted, there are a variety of measures covering several different topics and several different specialties. However, we did want to highlight our HHS Million Hearts Measures.

These measures actually were proposed to be called the "PQRS core measures." We received a comment, however, that – classifying the – these measures as PQRS core measures is confusing

because the EHR Incentive Program has core measures of their own. So we classified these are the HHS Million Hearts Measures.

These measures are related to cardiovascular care and we encourage the reporting of these measures. They're under slide 25 through 27. And we do not require that you report all these measures; however, we do encourage reporting of these measures.

On slide 29, it provides you kind of a snapshot of our individual measures set. So the total number of individual PQRS measures – we have 259 for 2013 and then 288 in 2014. The addition of the measures in 2014 is largely due to our alignment measures with the EHR Incentive Program.

For GPRO measures, as I indicated earlier, we are aligning with the Medicare Shared Savings Program. And so there will be 18 measures, including 2 composites, for reporting under the GPRO.

For help on selecting which measures to report, please see the "How to Get Started" section of the CMS PQRS Web site and contact the QualityNet helpdesk if you still have questions.

On slide 30 and 31, we provide you with the measures that were changed from 2013 and 2014. So we have the new measures for the 2013 PQRS. As you can see, there are 10 of them. We also have the list of measures that we retired for 2013, as well as the measures retired from GPRO and the new measure for GPRO in 2013.

Under slide 32, we have a summary of our measures groups that are available for reporting in 2013. There is – there is 21 currently in 2012, so that those 21 measures groups are noted on the left side or left column. And then in 2013, we're adding another measures group, the oncology measures group. And then for 2014 and beyond, we added four other measures groups – osteoporosis, total knee replacement, radiation dose, and preventive cardiology. So, basically, we're going to move from a total of 21 measures, currently; 22 measures in 2013; to 26 measures groups in 2014.

That ends the discussion for PQRS. Now, I'm going to move on to the Electronic Prescribing Incentive Program, starting on slide 33 and 34. Please note that we actually finalized the requirements for the eRx Incentive Program in – this calendar 2012 PFS Final Rule. The program actually runs only until 2014.

However, there were some updates made in the 2013 final rule related to the eRx Incentive Program. First, we established new criteria for the eRx group practice reporting option. And this is to account for adding the smaller groups, of 2 to 24 eligible professionals, under PQRS.

So these smaller groups can also participate under the eRx GPRO. Basically, these groups would report the electronic prescribing measure for at least 75 instances during the applicable 2013 eRx incentive or 2014 eRx payment adjustment reporting period. So in 2013, this GPRO would report 75 – electronic prescribing measures 75 times as opposed to 625 or 2,500 for the larger groups.

On slide 35, as indicated, we also finalized new significant hardship exemption categories for the 2013 and 2014 eRx payment adjustment. These hardship exemption categories are related to participation in the EHR Incentive Program.

So the first one is eligible professionals or group practices who achieve meaningful use during a certain eRx payment adjustment reporting period. The second exemption category is eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adopt a certified EHR technology.

Unlike the other exemption categories that we had finalized, for these categories, you don't need to affirmatively request an exemption under this category, so it's not like you have to into the communication support page and request an exemption online. Instead, CMS would take the information provided in the EHR Incentive Program's registration and attestation page to determine whether or not an EP would qualify for either of these exemptions, so we're going to do a back-end check to see who qualifies for those exemptions.

On slide 36, we have another update to the eRx Incentive Program and that's that we are implementing an eRx informal review process. This will be for the 2012 eRx incentive and 2013 eRx incentive, as well as the 2013 and 2014 eRx payment adjustment. So you have the one coming up, would be for the 2013 eRx payment adjustment.

The method to submit an informal review request would be via e-mail. The deadline would be 90 days following the receipt of the applicable full-year eRx feedback report. And more information on the eRx informal review process particularly related to the 2013 eRx payment adjustment is forthcoming.

On slide 37, we have our updates for Physician Compare. We have – under the final rule, we have basically laid out a plan for publicly reporting physician quality and patient experience metrics through the Physician Compare Web site. In addition, we continue to outline elements of that plan through rulemaking, even though, I guess not – these issues have not been posted or these facets have not been posted yet on the Web site.

So targeted for posting in 2014 are quality measures reported by group practice and ACOs participating in 2013 PQRS GPRO and are reporting via GPRO Web interface. Also targeted for posting in 2014 is patient experience data for group practices and ACOs of 100 or more EPs

reporting to the GPRO Web interface for the 2013 PQRS GPRO. Million Hearts Recognition for EPs reporting on a PQRS cardiovascular prevention measures group in PY 2013. Lastly, targeted for posting in 2014 is the recognition of EPs who earn a PQRS maintenance and certification incentive.

Under slide 39, we have the – we have the bullet of targeted for posting in 2015: individual-level measure data collected in 2014. Additional updates and information to be posted on Physician Compare include reduced public reporting threshold from 25 patients to 20 patients, measures developed and collected by specialty societies, and we also finalized a 30-day preview period prior to actual posting of data on Physician Compare.

Slide 40 and 41, as well as 42, provide you with resources as well as a phone number for the helpdesk, or actually the various helpdesks, if you have any additional questions and would like more information or help.

As you can see, on slide 42, we have the QualityNet helpdesk. The QualityNet helpdesk can answer any of your questions related to PQRS or the eRx Incentive Program.

The EHR Incentive Program information that are – this one, which is the last bullet – that is for any information and if you wanted more information related to the EHR Incentive Program. So, for example, if you wanted information on what's in your (registration and attestation page, then you would contact the EHR information center.

And that ends my presentation. I'll open it up for questions and answers.

Polling

Charlie Eleftheriou: All right. Christine, thank you. Before moving to Q&A, I'd like to quickly conduct keypad polling in order to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. Holly, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimized the government's teleconference expense by listening to these calls together in your office using only one line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 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.

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. Please continue to hold while we complete the polling.

Charlie Eleftheriou: And while we're holding, I'd like to take a second to remind everyone that this call is being recorded and transcribed. So for those calling in, please state your name and the name of the organization before asking your question and any CMS subject-matter experts addressing questions, please state your names as well when responding to callers.

In an effort to get as many questions as possible, we ask that your – you limit your questions to one at a time. If you have more than one question, please press star one to get back in the queue and we'll address additional questions as time permits. Holly, we're ready to start the question-and-answer session when the keypad polling is finalized.

Question-and-Answer Session

Operator: Thank you for your participation. We'll now move into the Q&A session for the 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 remember to pick up your handset before asking your question to ensure clarity. And please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Debbie Singer.

Debbie Singer: Hi. I've been waiting for this opportunity. This is about the eRx incentive. For whatever reasons, we were penalized during the current year, 2012, even though we'd filed for a hardship exemption. In any event, we were very careful; "we," meaning, we have two doctors in the office. We file under a group ID with each individual provider. So we were told, for the coming year, we had to submit 10 electronic prescriptions for each provider before June 30 and then a total of 25 for each provider before December 31. Is that correct?

Christine Estella: So it's a little different. So for the 2012 eRx payment adjustment, you were to your report, the electronic prescribing measure for any instance that you – electronic – or generated an electronic prescription.

Debbie Singer: Well, we did.

Christine Estella: So that should require the reporting of a measure.

Debbie Singer: At the minimum, I was told and I want to verify if that is correct, because I got conflicting information.

Christine Estella: Yes, it was 10 before June 30 for the 2012 eRx payment adjustment.

Debbie Singer: And 25 for each before December 31?

Christine Estella: Twenty-five is to meet the criteria for the 2011 – or 2012 – 2011 incentive, sorry.

Debbie Singer: Meaning – we have satisfied that. So beginning January 2013, we should not experience a penalty?

Christine Estella: Debbie, the 2013 payment adjustment is separate from the 2012 payment adjustment. So, meeting the requirements for the 2012 payment adjustment doesn't necessarily...

Debbie Singer: No, no, no, no. I'm looking to the 2013 payment...

Christine Estella: Yes.

Debbie Singer: ...adjustment.

Christine Estella: So that's actually a different – so that's – you have different criteria for the 2013 eRx payment adjustment. If we could get – if you could route your question, actually, to the helpdesk, we could find out specifically what your issue was with reporting in 2011 and we can probably answer you more specifically that way.

Debbie Singer: Well, right now, I want to make sure I'm OK for 2013.

Christine Estella: OK.

Debbie Singer: So I did – I did the 10 each for each doctor before June 30 and I did the 25 for each doctor now before the end of the calendar year 2012, so am I good?

Christine Estella: I wouldn't be able to answer that on this call.

Regina: So we have a separate reporting criteria for each payment adjustment year. Christine indicated the 2012 e-Prescribing payment adjustment is separate and distinct from the 2013 e-Prescribing payment adjustment. So we have a separate reporting criteria and reporting period.

So going to 2013 payment adjustment, your providers would have needed to have just one of a couple of things. One, it would have had to have reported 25 e-Prescribing instances from dates of service January 1, 2011 through December 31, 2011.

Their second option would have been to report 10 e-Prescribing instances from dates of service January 1, 2012 through June 30, 2012. And then their third option to avoid the 2013 prescribing payment adjustment is, if they are subject to a significant hardship exemption, they could have submitted that hardship either during the dates of March 1, 2012 through June 30, 2012 or, as we announced earlier on the call, we have re-opened the 2013 hardship exemption window for – if your providers were or are subject to a hardship exemption and for one reason or another you weren't able to apply that, you could do that now.

But as Christine was mentioning, we do have a dedicated helpdesk. And if we can get your contact information, we can have the helpdesk look into your specific issue or your provider's specific situation and we can figure out what happened for the 2012 year. And we should be able to...

Debbie Singer: Clarify?

Regina: ...see what's happening for the 2013 year.

Debbie Singer: OK. Now, how do I do that?

Regina: If you can just give us your name and your phone number, we can have that on the helpdesk.

Debbie Singer: OK. It's Debbie Singer.

Regina: And what's your phone number?

Debbie Singer: 718-258-8383. No extension.

Regina: Thank you very much.

Debbie Singer: Thank you for your help. Bye-bye.

Operator: Your next question comes from the line of Thomas Beach.

Thomas Beach: Hi. This is Tom Beach. I'm –

Charlie Eleftheriou: Hello.

Thomas Beach: My question has to do with the GPRO. We have four TINs in our facility: one for our primary care physicians, one very large one for our specialty providers, one for our international physicians, and another one for our hospital list. If we were to go to the GPRO, would we have to provide information on – what? 21 measures – well, wait a minute – 33 measures now?

Christine Estella: It's actually – it's 18. So, first off, let's talk about your group practice. So you group practice has four different TINs...

Thomas Beach: Correct.

Christine Estella: ...under the GPRO. Each group – each TIN would have to be a separate group practice because that group practice under the GPRO is defined as a single TIN.

Thomas Beach: OK.

Christine Estella: So that would be the first thing. So you would have four different group practices participating under the GPRO. And then – this is for next year, so, basically, these group practices would have two options to report for the incentive. They could either use the registry-based reporting mechanism or the GPRO Web interface.

Thomas Beach: Yes.

Christine Estella: And then – and then for the GPRO Web interface, you would report 18 measures.

Thomas Beach: So there'll be 411 patients for each measure?

Christine Estella: Well, it would depend on the site and your group. But, generally, yes, that's for a large GPRO.

Thomas Beach: Well, all but one is below 100.

Christine Estella: Yes. Yes. And so this – also – this is also – the choices are also depending on if you are not participating as an ACO under the Medicare Shared Saving Program, and there are a couple of exceptions if you are participating as an ACO under that.

Thomas Beach: OK. All right. Thank you.

Christine Estella: No problem. If you have any additional questions, you should contact our QualityNet helpdesk. They should be able to give you more information on your specific group and how to get started to participate for next year.

Thomas Beach: OK. Thank you.

Christine Estella: Thanks.

Operator: Your next question comes from the line of Tina Shaffer.

Tina Shaffer: Hello. My name is Tina Shaffer. I'm calling from Neuropsychiatric and Counseling Associates.

Christine Estella: Hi.

Tina Shaffer: Hi. I'm not sure if I'm at the right place to ask this question, but I'm curious about physicians versus nurse practitioners, as far as billing codes. We had received some information that there were changes coming in the psychiatric field, where a physician would need to bill a certain procedure code versus a nurse practitioner billing; specifically, 90792 versus 90791.

If you don't know the answer, is there someone you could point me in the direction to ask that question to?

Christine Estella: Sure. Actually, this call handles mainly quality reporting for the – for the final rule under the PFS, so I do know there are certain codes that were modified under the PFS as well. We have to redirect your question, so if we could take your name and phone number?

Tina Shaffer: Sure. It's Tina Shaffer.

Christine Estella: Tina? Is it Tina Shaffer?

Tina Shaffer: Yes, ma'am.

Christine Estella: OK.

Tina Shaffer: And my phone number is 703-971-1936.

Christine Estella: OK. Thanks.

Tina Shaffer: Yes. You're welcome. Thanks. Bye-bye.

Operator: Your next question comes from the line of Jerry Filling.

Barbara Maxwell: Yes. My name is Barbara Maxwell and I work for Dr. Filling. And I would like a clarification. Hopefully, this will appear in writing. We've been a successful PQRS person group or individual practice in 2007. All of a sudden, I'm receiving remittance notices where there is no N365 following the PQRS code.

I have spoken with our carrier and they say it was a processing error on our part. But they cannot reassure me that this goes in, and I was under the impression that for me to check to make sure that we're compliant, if I see that N365, I know that that PQRS code has been recorded. Is that correct?

Christine Estella: Yes. In general, you should see the N365 code, so that notes basically that you have submitted a G code for reporting purposes.

Barbara Maxwell: Right. So I have a remittance notice where 60 percent of the claims that were put on it don't have N365 or one of the PQRS codes has an N365 for an individual claim. We are filing paper claims, so there was no second party, third party or whatever. How can I get this corrected proactively before the end of this year, because I'm – I've got – have one remittance with 60 percent, another with 50 percent, and this is just totally unusual.

Dr. Daniel Green: Who's your carrier?

Barbara Maxwell: Novitas.

Dr. Daniel Green: OK. So if you could give us your contact information, we'll have somebody from –

Barbara Maxwell: I went to Quality Help and I explained the situation to them and they said if we were told at the national claims history that these things went in, then we're OK. What I was told by Novitas was, we – the manager and the person I spoke with said, there is – we could find

nothing in writing that says there has to be an N365, but they did say it was a processing error – so I'm – you know, I'm –

Dr. Daniel Green: Hang on for us just one second.

Barbara Maxwell: OK.

Charlie Eleftheriou: All right. We're going to put you on hold for a quick second.

Barbara Maxwell: Thank you.

Charlie Eleftheriou: Yes.

Christine Estella: OK, ma'am. So if we can get your contact information, we will follow up with this with our helpdesk and we'll look into the issue. So if you can give me your name and phone number?

Barbara Maxwell: OK. It's Barbara Maxwell or Terry Lewis. Either one of us can handle it. And the phone number is 301-777-1051.

Dr. Daniel Green: Are you – are you submitting these yourself or are you going through a billing service?

Barbara Maxwell: No, no, no. We're submitting paper claims ourselves. And when I go back to look at the remittance notice and I compare it to a copy of the claim we have, everything on the claim is correct, we have the PQRS with the proper – I mean, as I said, we've been successful since 2007, and this has just happened recently where 60 percent of the claims are missing the N365 or they separate the PQRS and say – from the office visit code – and say they were doing the office visit code separately and then we have a PQRS code on the remittance notice. This is unusual.

Christine Estella: OK. So we will definitely speak with the carrier to look into your issues. And while we have you on the phone, I did also want to mention that we do have additional reporting options available for the 2012 year. I know that your group has taken the effort to put your G codes on the paper claims and we appreciate that. But we do have a registry reporting option.

Barbara Maxwell: Yes. We're happy because we've got a system that works. It has worked every year, and then all of a sudden we're getting these, where 50 percent of the claims are – you know, and you may get one N365, and we're reporting – we could report four or five PQRS codes on there. And one will have it, but the other won't, or none of them will have it. It's just –

I understand about the registry and all that. But we're good with what we're doing because we know what we're doing.

Regina: OK. Well, thank you. We will look into this with the carrier thing.

Barbara Maxwell: OK. I appreciate your help. Thank you.

Operator: Your next question comes from the line of Martha McGee.

Martha McGee: My name is Martha McGee. I'm calling from Peripheral Vascular Associates and I have a question regarding a line in the implementation guide for 2012.

Christine Estella: OK.

Martha McGee: It has to do with the assistant surgeon. And it says that they will be excluded from the denominator population, so their performance rates will not be negatively impacted for PQR. Now, does that mean that I should not be reporting at all for the assistant surgeon? And will that count against them if I've already – if it has been coming up on our reports as being counted?

Dr. Daniel Green: So if doctors were billing as an assistant surgeon, so –

Martha McGee: I have the surgeon and the assistant in my practice.

Dr. Daniel Green: OK. So the primary surgeon, obviously, would be responsible for the quality code if that – for the measure that he or she is reporting. Excuse me. So, obviously, if they're reporting a given measure, you know, a given surgery measure, they would need to append the CPT 2RG code to that. Your assistant surgeon, what are they billing, under a 25 modifier, I think it is?

Martha McGee: Eighty.

Dr. Daniel Green: Eighty. Thank you. So if they're billing under an 80 modifier, they would not be held accountable for the measure. It would – it would not count against them if you have been reporting it for them, but it wouldn't count for them either. So it wouldn't have any impact on them if there's the 80 modifier.

Now, if they were co-surgeons, it could be different, but if they're primary and assistant, it should not impact the assistant at all.

Martha McGee: OK. So when I'm looking at the numbers, for example, from 2011, so that means that it has been reviewed and it didn't get counted. It just seems to me as if it is – it was, I mean.

Dr. Daniel Green: Well, so it should be counted in terms of your incentive payment. So if that assistant's fee was, let's say, $100, you should be getting, you know – last year, you should have gotten about 1 percent of, you know – counted towards the overall incentive, because those are your provider's Medicare Part B charges. But the actual code should not have been counted in terms of whether or not he or she qualifies meeting the 50 percent threshold, for example.

Martha McGee: OK. And we – OK. So the assist probably did not receive the incentive –

Dr. Daniel Green: No, no, no. The assist, we get – you know, whatever the charge is for the assistant – the assistant fee earned for being an assistant, that would count in the incentive payment, but it would not count for or against that person for the quality reporting.

Martha McGee: OK. So I'm not hurting him by reporting it anyway?

Dr. Daniel Green: No, you're not.

Martha McGee: OK. I wanted to make sure there's no issue with that now. I know it's pretty tough. We've already been it for the whole year, but just to be on the safe side.

Dr. Daniel Green: No penalty in over-reporting. It's only under-reporting that can be an issue.

Martha McGee: Got it. Thank you very much.

Dr. Daniel Green: Thank you.

Operator: Your next question comes from the line of Diane Martin.

Diane Martin: Hi. This is Diane Martin from Upper Bucks Family Medical Center and this will be our first year in 2013 doing PQRS. And I'm just wondering – we have a two-provider group. I'm wondering, what's the advantage or disadvantage doing EP versus group reporting?

Christine Estella: Sure. I think really the particulars of your group practice and how your group practice is administered would depend on whether or not you want to do individual or group practice reporting. If you're only a group of two eligible professionals though, for individual reporting, you have the claims, registry, and EHR-based reporting mechanisms available to you

for 2013. However, as – if you're participating as a group practice under the GPRO, you only have that registry-based reporting mechanism.

Diane Martin: So we could – so – if we do individual, we would do G code reporting just like we did for eRx?

Christine Estella: OK. So that's claims. So that is actually only available for individual reporting under PQRS.

Diane Martin: OK. So – but I could choose to do that with each provider or no, I could not choose to do that each provider?

Christine Estella: Yes. You could do that with each provider, so then you'd have to track the reporting for each provider separately. So just make sure that, you know, you report – that you're reporting for both providers for the amount, for the number – the minimum number of measures. So if you're using the claims-based reporting mechanism, for example...

Diane Martin: Right.

Christine Estella: ...for the 2013 incentive, you would report at least three measures for each eligible professional or for both of them, three each.

Diane Martin: OK.

Christine Estella: Then you would make sure that they would – you're reporting at least 50 percent of your applicable patients.

Diane Martin: OK. OK.

Dr. Daniel Green: What kind of – what kind of doctor practice are you guys?

Diane Martin: It's a family practice.

Dr. Daniel Green: So far be it from me to suggest what you should do –

Diane Martin: I'll take your advice.

Dr. Daniel Green: But I will mention a suggestion, anyway –

Diane Martin: OK.

Dr. Daniel Green: You're – if you would choose to report individually, which, off the record, since we're only on with 500 of our closest friends –

Diane Martin: Right.

Dr. Daniel Green: I would report, honestly, using a measures group because...

Diane Martin: OK.

Dr. Daniel Green: ...you know, it's predictable, in that you only need to report on 20 patients.

Diane Martin: OK.

Dr. Daniel Green: Now – so, unlike diabetics, where you don't – where they go see 50 in a year or 100 in a year, or how many...

Diane Martin: Right.

Dr. Daniel Green: ...you'd have to report on, you know, 50 percent. When you report on measures group, while it is more measures for your docs to report, it's limited to only 20 patients.

Diane Martin: OK.

Dr. Daniel Green: So you'll know, like, after you reported on the 20th patient – I always tell people to report on a couple of extras just to be on the safe side.

Diane Martin: OK. Right.

Dr. Daniel Green: But you're done. And you don't have to worry if you suddenly see another onslaught of – you know, another 30 diabetics, for example, and you're doing three diabetes measures. So...

Diane Martin: So measures group typically has how many measures in it?

Christine Estella: There are at least four measures on a measures group.

Dr. Daniel Green: And it depends on the – you know, the measures group. But, you know, if they're family practice, chances are, they're doing a lot of, you know, preventive care type thing.

Diane Martin: Absolutely.

Dr. Daniel Green: There is a preventive care measures group and there is a document we have on our Web site. I believe it's, "Measures Groups Made Simple."

Diane Martin: OK.

Dr. Daniel Green: You know, it kind of walks you through very nicely how to participate. And, again, you can participate on any which way you want. You can do three measures, you can do a measures group, you can go EHR registry, all that other stuff. But from what you've indicated, it sounds like you want to do claims and while, again, there are 250 somewhat measures that you could report…

Diane Martin: Right.

Dr. Daniel Green: …this may be an easier way for you to kind of immerse yourself in the PQRS culture. So anything you want to do is fine, but this just a friendly suggestion.

Diane Martin: And measures groups might be the way to get our people into this.

Dr. Daniel Green: It's just a suggestion.

Diane Martin: OK, great. Thank you very much.

Dr. Daniel Green: You're welcome.

Operator: Your next question comes from the line of Kathy Reeves.

Kathy Reeves: Yes. I have a question regarding e-Prescribing. If we are using meaningful use and reporting that way, do we still have to record the G codes so that we don't get penalized?

Christine Estella: Yes. So, actually, the two programs are separate. So the eRx Incentive Program is different from the EHR Incentive Program. So I know there is an electronic prescribing component under the EHR Incentive Program, but you would still need to report the eRx measure under the eRx Incentive Program.

And I did mention though for the 2013 – starting with the 2013 payment adjustment, we did finalize two significant hardship exemption categories related to participation under the EHR Incentive Program. So, for example, if you achieve meaningful use at some point in 2011 or the first 6 months of 2012, you would probably qualify for a hardship exemption.

Kathy Reeves: OK. So if we're doing it the last quarter of 2012, then we won't qualify.

Christine Estella: You probably wouldn't qualify under the achieving meaningful use category. There is also another category, though, if you registered and participate in the EHR Incentive program and have adopted a certified EHR technology. So in that registration and attestation page, if you click your CEHRT product number on there...

Kathy Reeves: Yes.

Christine Estella: ...you may be able to qualify for an exemption and that would just depend on the information you provided in the registration and attestation page.

Kathy Reeves: And we wouldn't know that until after the fact?

Christine Estella: As to whether or not you qualify...

Kathy Reeves: Yes.

Christine Estella: ...for the exemption? Yes. That would be – because that would be done on the back end by CMS.

Kathy Reeves: Just real quick, does that qualify for PQRS also?

Christine Estella: No, it does not qualify for PQRS.

Kathy Reeves: OK. So we don't need to worry about it.

Christine Estella: Yes.

Kathy Reeves: OK.

Christine Estella: But I will say, to be in the safe side, if you could report the e-Prescribing measure, that would probably get you in a better spot.

Kathy Reeves: OK. And just the first 6 months to avoid the penalty, right?

Christine Estella: Yes.

Kathy Reeves: OK. All right. Thank you.

Christine Estella: Thanks.

Operator: Your next question comes from the line of Lina Parekh. Lina, your line is open. And that question has been withdrawn. Your next question comes from the line of Shelly vantRiet.

Shelly vantRiet: This is Shelly vantRiet from VCU Health System. We're a group of over 100. If we report by the method of a group EHR in 2014 or PQRS and meaningful use, will we get incentives for both? And I also have a follow-up question on when the 2013 GPRO specs will be available on the Web site.

Christine Estella: So I guess it would depend, I would say. But for PQRS, we did align – so we did align the reporting criteria in 2014 with the EHR Incentive Program criteria.

So, essentially, yes. If you submit one set of data under CEHRT, you essentially should be able to get the PQRS incentive and meet the CQM component of achieving meaningful use because, as you know, there are other components related to achieving meaningful use under the EHR Incentive Program.

But our requirements – our criteria did align. So, basically, if you're reporting nine measures covering three domains, you should be OK as long as you make sure that you're reporting on, you know, applicable patients; for example, you're having – you have at least one applicable patient you're reporting on. Does that make sense?

Shelly vantRiet: Yes. Thank you.

Christine Estella: OK.

Shelly vantRiet: And can you tell me when the 2013 GPRO specs will be available on the Web site?

Christine Estella: OK. Hopefully, by next week, we should have the GPRO specs available.

Shelly vantRiet: Thank you.

Christine Estella: Thank you.

Operator: Your next question comes from the line of Christie Hunt.

Christie Hunt: Hi. My name is Christie and I'm calling from Heart Care Services of Florida. We are a three-physician interventional cardiology practice. And we went independent effective 6/1

– we were under a hospital – we were contracted with a hospital prior to that, so all of our billing and everything was through hospital. Effective 6/1, we became independent.

We've already met our 90-day meaningful use incentives, but all of this PQRS and now this electronic prescribing incentive program is brand new. We haven't heard of it. We had a billing company who did our meaningful use, but this other PQRS and this eRx is – we haven't been told about.

So can you advise me as to where I need to begin to make sure we get on top of this incentive? And we're completely, you know, EHR-based and – but we haven't done anything claims-based. And, to my understanding, to do PQRS for 2012, we could only do the registry-based because we only have 6 months, you know, where we went live independent, is that correct?

Christine Estella: Yes. So there is a 6-month reporting period to registry. So – and that happened – that occurred starting July 1. So, depending on, you know, whether or not your system was ready and up for implementation, that may have been your option. You could have also reported using claims earlier in the year.

Dr. Daniel Green: Excuse me, Christine, I'm sorry. Just real quick. Since – you probably are under a new tax ID number since you separated from the hospital, correct?

Christie Hunt: That's correct.

Dr. Daniel Green: OK. So you could look up a – on our Web site, there's a list of qualified registries. There is also a list of qualified data submission vendors.

Christie Hunt: Yes.

Dr. Daniel Green: You could look up one of those and contact one of those qualified entities. And since you're using an EHR, it shouldn't be too hard actually. They – you could go back in your system and report that information to them on the patients you've seen – let's say, since June 1 through the end of the year under your current tax ID number – and you still may qualify for the full 7 months' worth of incentive even though, obviously, you've only been reporting for 7 and not 12 months.

Christie Hunt: OK.

Dr. Daniel Green: It would be from the charges that you started under – that you had submitted under your new tax ID number.

Christie Hunt: OK. So we can go back – because we were – because we were looking under – we were looking under group measures and – but – how can we go back? Wouldn't those measures already have needed to be in place to know what we were measuring? I mean –

Dr. Daniel Green: No, not necessarily. Because, like – for example, I'm just going to pick a measure. Let's say, it's the mammography measure that you wanted to report. I know I heard you say you're a cardiologist, but go with me for a second.

Christie Hunt: OK.

Dr. Daniel Green: You could go back to see all the women that you all saw between the ages of 40 and 69, starting January – I'm sorry, starting June 1.

Christie Hunt: Yes.

Dr. Daniel Green: You know, and then submit – that would be your denominator for the measure, assuming they didn't have any exclusions like mastectomy or whatever. And then you would just go back and report for each one of those patients – you know, had a mammogram, didn't have a mammogram, whatever – to the registry.

Sometimes the registries, depending on what software you're using, some of the data submission vendors and/or registries may actually be software companies. So if you're a company which, depending on what system you're using, is one of those companies, they can sometimes just go in and data-mine your system to pull the information. You really don't have to do too much if that's the case.

Christie Hunt: OK. So we can select the four measures now and pull that out and find the registry group to submit this through?

Dr. Daniel Green: Right. So what I would do is, I would contact the registry or data submission vendor first because you want to make sure that whoever you're going to sign up with is going to do the measures that you want to report on.

Christie Hunt: OK.

Christine Estella: And if you did have more questions to, you know, different registries and the measures groups available, you could also contact our helpdesk.

Christie Hunt: OK. And what about the – what about the e-Prescribing Incentive Program?

Christine Estella: So the e-Prescribing Incentive Program, the reporting period for the 2012 payment adjustment was over – I don't know if your providers – are your providers currently experiencing a 2012 payment adjustment of 1 percent?

Christie Hunt: Not that – I mean, it hasn't been brought to my attention.

Christine Estella: OK.

Christie Hunt: I haven't.

Christine Estella: OK. So that – and that – the reporting period for that is over, so then I guess what we're focusing on now is the 2013 and 2014 eRx payment adjustment. As Dr. Daniel Green noted, for the 2012 reporting period year, you may be able to still report, and that would be in addition to PQRS. You may still be able to report for the e-Prescribing Incentive Program using a registry.

Christie Hunt: OK.

Christine Estella: For the 2012. So that may get you out of the 2014 eRx payment adjustment. For the 2013 eRx payment adjustment, the reporting period is over. We do have...

Christie Hunt: Which was when – what was the reporting period?

Christine Estella: It was – well, it was the calendar year – full calendar year 2011 and...

Christie Hunt: We weren't in place yet.

Christine Estella: Yes. And then you have additional 6 months until June of 2012 this year.

Christie Hunt: OK.

Christine Estella: But if you're doing the EHR Incentive Program, you may have been able – you may be able to qualify for an exemption. As I noted earlier, there are two exemptions related to the EHR Incentive Program that we just finalized.

Christie Hunt: Yes.

Christine Estella: Let me see. That is on slide 35.

Christie Hunt: OK.

Christine Estella: So I would – I would contact the EHR information center and information is on slide 42, when I would check to see what's in your registry – what information you have submitted under the registration and attestation page or (inaudible) and you can start with there. And then if you had other questions about these exemption categories, you could contact our QualityNet helpdesk for that information and that's also – that is – that information is also on slide 42.

Christie Hunt: OK, great.

Christine Estella: So the EHR information center for your registration and attestation page information and the helpdesk for the actual exemption.

Christie Hunt: OK, great. And then I saw – I saw your registries in there. There's like a ton of registries to choose from. I mean, it is just a matter of choosing one?

Christine Estella: Yes. I mean, I would contact...

Christie Hunt: We're using clinical work for our – for all of – for our EHR and they're – they aren't a registry yet for 2012.

Christine Estella: I would – you know, I would contact the helpdesk for help on selecting a registry maybe. They may be able to narrow the list down for you.

Christie Hunt: OK. OK, great.

Christine Estella: No problem.

Christie Hunt: Thanks for your help. I appreciate it.

Christine Estella: No problem.

Operator: And your next question comes from the line of Melinda Peloquin.

Melinda Peloquin: Hi. Good afternoon or good morning. My name is Melinda and I work with OTAC, and please forgive me, as I'm not a Medicare participating provider, but I do have a question in regards to PQRS. And I'm just wondering, if you can help clarify for me, who exactly is considered an eligible professional under the PQRS? And does that include individual, occupational, and physical therapists and private practice?

Dr. Daniel Green: Give us one quick second please.

Melinda Peloquin: OK.

Christine Estella: So eligible professionals actually consist of a whole range of professionals – M.D.s, for example; D.O.s; certain practitioners that aren't physicians; for example, a physician assistant, nurse practitioner, certain therapists, physical therapists, occupational therapists, qualified speech language therapist. Is there a particular –

Melinda Peloquin: Yes. Is that in regards to, like, hospital out-patient rehabilitation? I'm talking about individual therapists in private practice doing Part B. I'm just – again, I apologize. I'm looking at page 30, the PQRS individual measures, and then the ones that are retired, and –I'm sorry, bear with me – that the retired 2013 PQRS individual measures are no longer in use. And then on page 32, there is only, according to my experience, over the last 12 years, there's only maybe three, possibly four of the current 2012 measures for groups that would be available for reporting for 2013 and beyond that would apply.

Regina Stewart: Can we just kind of back up and let's kind of re-frame your question because...

Melinda Peloquin: Sure.

Regina Stewart: ...it sounds like you may be asking a couple different things so I just want to clarify that so – this is Regina. It sounds like you're asking about eligible professionals for PQRS, it sounds like you're asking about the qualifying measures for PQRS, and it sounds like you're also asking about location (inaudible) –

Melinda Peloquin: Yes. I'm just trying to understand if the therapy professionals in private practice not affiliated with a hospital do qualify under PQRS and then...

Dr. Daniel Green: That answer would be yes.

Melinda Peloquin: OK. And then based on my understanding of the current 2012 measures groups for reporting in the year 2013, there's only a few that would qualify for out-patient care that are listed here – Parkinson's.

(Male 1): What kind of providers are you calling on behalf of?

Melinda Peloquin: I'm calling on behalf of Occupational Therapy Association of California but I also work with APTA for physical therapists and I'm just trying to get clarification.

Dr. Daniel Green: So for OTAC basically.

(Jamie Welch): Hi. This is Jamie from (Timber). Some options that you may be able to look at for reporting of the functional measures that are found in the – I think you're looking at measure group specifications. And I think you need to go to the individual measures specifications, and what's in those specifications are – there are measures that relate more to your practice and they're in the 200s, like, 201 to 210s and their functional measures. But we can help you through that too if you contact the helpdesk ...

Melinda Peloquin: OK.

(Jamie Welch): ...and you give us the codes that you are billing. We can do a search for you and help you through that if you like.

Melinda Peloquin: OK. That would great. I just want to make sure that the members have enough information in order to understand – it is relatively confusing. Sorry.

(Jamie Welch): Yes. No problem. We can also help you through any other questions that you might have. So I guess go ahead and contact the helpdesk and my name is (Jamie Welch) and the ticket will find me. I promise.

Melinda Peloquin: OK. Thank you so much.

(Jamie Welch): You're welcome.

Melinda Peloquin: OK. Have a good day.

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

Debra Farley: Yes. My question is, insofar, is how do providers avoid the 2 percent payment adjustment in 2014? Do they still put the G8553 on claims?

Christine Estella: So this is for – this is for the eRx Incentive Program and I believe you're talking about the 2014 eRx payment adjustment. And, yes, the criteria basically – we established it in last year's rule, so that's why I didn't cover it in this presentation – you would report the electronic prescribing measure. If you didn't do so already for this reporting period in 2012, in 2011 next year you have – 2013 next year, you have the first 6 months of 2013 to report the G8553 code 10 times.

Debra Farley: And that can be on claims, correct?

Christine Estella: Yes.

Debra Farley: OK. I just want to make sure. Thank you.

Christine Estella: No problem.

Operator: Your next question comes from the line of Diana Poncelet.

Diana Poncelet: Good afternoon. We're a group of 95 physicians – well, it will be close to 95 physicians, getting close to 100. And I'm looking at what you have for the future. It looks like GPRO is going to be our only option in two years.

We have several providers in the group. Their hospital lists one tax ID. Now, by going to the GPRO option, everybody should be exempt from the adjustment if we do meet every – the qualifications, then?

Christine Estella: OK. So let me – let me backtrack and make sure I understand the nature of your practice. Are you saying that you would be required to participate in the GPRO because you are a group of – are you a group of 100 or more?

Diana Poncelet: We're right at that threshold. We have a mixed-specialty practice with, at this point, I believe we have just over 90 and we're looking at adding 95. But if you – I'm not sure. If you look at PECO and how many MPIs are registered under us because, we have some open for – some providers have left. We have claims open.

Christine Estella: Great. So you're a group of around 100 or more.

Diana Poncelet: Yes. Let's say, 100 just for –

Christine Estella: Are all the EPs are billing under one TIN?

Diana Poncelet: Yes.

Christine Estella: Yes. So then, I guess, your question would relate kind of to two certain programs. I'm assuming it relates to PQRS, first of all, and then I think you also probably have a value-based modifier question.

Diana Poncelet: Right. Because right now, we're successfully doing the claims base for the e-Prescribe and the PQRS. But, again, not all providers participate with this, because there are measures that don't apply to them. And my biggest fear is, you know, is this value-based modifier going to be applied to these providers that aren't able to really report out?

Christine Estella: So there is – under the value-based payment modifier, there is an option to report as – there is an option that you would be able to report as an individual under PQRS. But for the value-based payment modifier, you would have to choose the admin claims-based reporting mechanism.

So, yes, you kind of have to do two things to satisfy the requirements for PQRS and the value-based payment modifier if you wanted to continue to report individually.

Diana Poncelet: OK. So it'd be better than to go GPRO. And, you know, it's looking like from one of the slides that we'd have to go to GPRO anyway once we hit 100 in 2014?

Christine Estella: Actually, no, no. You still – under PQRS, you still have the option of doing either individual reporting or group practice reporting and that will also continue to 2014.

Diana Poncelet: OK.

Christine Estella: I think your situation is a little bit more complicated since you're a larger GPRO. Your question is, how do you more efficiently – you know – meet the requirements for PQRS and the value-based payment modifier?

Diana Poncelet: Yes, definitely. Is there something out there – I've tried looking on the Web to see you have some of the payments made simple, but it'd be nice to see, you know, just a future suggestion, how – what the reporting looks like, how it works.

Regina: You might be interested in our National Provider Call on the 28th when we're talking about the value-based payment modifier and you can register at the same site you registered for this call.

Diana Poncelet: OK.

Regina: We also have a Web site that within the next three or four weeks will have more information about the value-based payment modifier. It's www.cms.gov/physicianfeedbackprogram – all small letters, all one word, no spaces.

Diana Poncelet: OK. Sounds good. Thank you so much.

Regina: Sure.

Christine Estella: And I just want to address your other issue. You had mentioned the group practice, that some of your EPs report and some don't. This is an FYI. For PQRS, if you're

reporting individually, every eligible professional that has applicable measures will have to report a PQRS starting next year, so that irrespective of what you should do for a value-based payment modifier, so I would make sure – I know you said there are no applicable measures to an EP or certain EPs in your practice. I would contact the QualityNet helpdesk to make sure that that certainly is the case, there are no applicable measures, because sometimes, under our program, just because you don't have a specific measure applicable to your practice, there could be other measures that you could report on. So I just want to make sure that you're covered.

Diana Poncelet: OK. And they'd be able to provide the information report based upon...

Christine Estella: Yes. Yes. If you give them, you know, more information as to, you know, what kind of specialties your – what you bill.

Diana Poncelet: OK.

Christine Estella: So these providers, they should be able to provide you with advice on which measures to report.

Diana Poncelet: Great. Thank you so much.

Christine Estella: No problem.

Charlie Eleftheriou: Holly, I think we have time for one more question.

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

Therese Blalock: Hello.

Charlie Eleftheriou: Hi.

Therese Blalock: Hi. I'm calling from Hamilton Physical Therapy in Montana and I have a question as to or not EHR reporting will be required of individual practitioners in the next couple of years. I'm a little bit confused by the one slide that – as to whether or not we continue – can continue to do claims-based reporting or if we have to do EHR.

Christine Estella: Sure. This is – this is Christine. So yes, the claims – we have actually finalized the claims-based reporting mechanism for – I think last year, we finalized it for 2012 and beyond. So you will be able to use it for subsequent years.

It's just, basically, we had proposed to be able to use the claims-based reporting mechanism under the group practice GPRO, but we did not finalize that proposal. So the only way you'd be able to use the claims-based reporting mechanism is if you're reporting individually.

Therese Blalock: OK. So what does that mean when it says requirement of a certified electronic health record technology for eligible professionals and group practices?

Christine Estella: What slide are you referring to?

Therese Blalock: Seven. I mean, we're a group practice – we're – are physical therapists as individual practitioners.

Christine Estella: Right. That's – the PQRS and the EHR is in their program. That kind of just exceeded our goals. So one of the ways in which we align with the EHR incentive program is that if you are using the EHR-based reporting mechanism, we would require that your product be CEHRT beginning in 2014.

Therese Blalock: But you – but we can for the next – for the foreseeable future use claims-based reporting?

Christine Estella: Yes. You can – you can still use claims-based reporting from, you know, now and beyond.

Therese Blalock: To infinity and beyond.

Christine Estella: Yes.

Therese Blalock: I wish I was having as much fun as you, but – OK. Thank you.

Christine Estella: No problem.

Therese Blalock: Bye.

Additional Information

Charlie Eleftheriou: All right. Thank you. That is all the time we have for calls today. If we did not get to your questions contact the quality support helpdesk at 866-288-8912 from 7 a.m. to 7 p.m. Central Standard Time, Monday through Friday or e-mail qnetsupport@sdps.org. That and additional information is available on slide 42 of today's presentation.

Please note, while we may not be able to address every question, we'll review them all to help us develop frequently asked questions, educational products, and future calls and messaging. On the last slide in today's presentation, you'll find information and a URL to evaluate your experience with today's National Provider Call. Evaluations are anonymous and strictly confidential.

I'll also point out that all registrants will receive a reminder e-mail from the CMS National Provider Call's e-mail box within two business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you've already completed the evaluation, but we appreciate the feedback.

I'd also like to thank everyone one last time for participating in today's call. An audio – an audio recording and written transcript will be posted to the Physician Quality Reporting System and National Provider Call's Web pages on the CMS Web site in approximately three weeks. Have a great day everyone and thanks again.

Operator: Thank you for participating in today's conference call. You may now disconnect.

END