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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Medicare Quality Reporting Programs: Data Submission Process MLN Connects
National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects 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 today's call over to Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you, Salema. Happy New Year, everybody. And as Salema said, this is Aryeh Langer from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everybody to this MLN Connects National Provider Call on the Medicare Quality Reporting Programs Data Submission Process.

MLN Connects calls are part of the Medicare Learning Network. During today's call, CMS subject matter experts will provide an overview of the 2014 Submission Process for Medicare Quality Reporting Programs, including the Physician Quality Reporting System, also known as PQRS, Value-Based Payment Modifier and Electronic Health Record or EHR Incentive Program.

The presentation provides information for eligible professionals and group practices submitting 2014 data and guidance on how eligible professionals in PQRS group practices can earn the 2014 PQRS incentive, and avoid the 2016 negative PQRS payment adjustment through these reporting mechanisms. A question-and-answer session will follow today's presentation.

Before we get started, there are few items I'd like to quickly cover. You should have received the link to the slide presentation for today's call and an email earlier this afternoon. If you have not yet seen the email or you did not receive it, you can find today's presentation on the call details web page on the CMS website, which can be found by visiting www.cms.gov/npc. Again that URL is www.cms.gov/npc.

On the left side of that page, select National Provider Calls and Events, then select today's call by the date from the list on that page. The slide presentation is located there in the call material section.

I'll also note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS call details web page. When it is available, an announcement will be placed in the MLN Connects Provider eNews.

Finally, today's call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, please review the CE Activity Information & Instructions available via the link on slide 39 of today's presentation.

At this time, I would like to begin the formal part of our presentation by turning the call over to Lauren Fuentes from CMS.

Presentation

Lauren Fuentes: Thank you, Aryeh. This is Lauren Fuentes with the Center for Clinical Standards & Quality, and I will be providing the presentation for today. So, good day and happy new year to all our participants on the call. We do appreciate you taking the time to join us today, and also hope that you find the information useful. So let's go ahead and get started on slide four for an overview of what we've planned to discuss today.

So for slide four, we will begin by talking about the 2014 Physician Quality Reporting System Submission Information. And just a reminder, the PQRS – the 2014 PQRS data is used for other quality reporting programs such as the value modifier and the EHR Incentive Program. So we will be going over the submission details for how to submit through a Qualified Registry, a Qualified Clinical Data Registry or QCDR, Electronic Health Record or EHR-based Reporting, Accountable Care Organization (ACO), and PQRS Group Practice Reporting Option, the GPRO web interface. And we'll also be touching on the Maintenance of Certification Program submissions.

So I do just want to let the group know today that we will be speaking generally around submissions. If there are specific questions about any issues you're having with your 2014 submission, just a heads up that we will be asking you to contact the QualityNet Help Desk for those, but during today's call we can definitely help you with kind of general guidelines around submissions.

In part of this presentation, we also have provided resources and who to call for help. We will be having a question-and-answer session after the presentation. And also in your slides, I just wanted to point out the appendices and these appendices – I won't be going over these appendices in detail, but what we provided there is just the 2014 PQRS reporting requirements, so I think that's a helpful resource for you in terms of what is required for each reporting mechanisms because they are different.

2014 Physician Quality Reporting System (PQRS) Information — OK, so let's go ahead and move on to slide six and get started on just some general information around PQRS participation. So at this time, we're in early 2015, so at this time, there are limited options for reporting your program 2014 data.

So, registration for the Group Practice Reporting through the Group Practice Reporting Option or GPRO did end on October 3, 2014. So if you didn't register as a GPRO for 2014, you must report individually. And just note that it is late at this point to start participating via claims-based reporting. Claims-based reporting is really an option that is better for you to be reporting throughout the calendar year, so that would have been 2014. So we're not going to discuss claims-based reporting at this time.

And as I mentioned earlier, PQRS participation may also satisfy requirements on quality data for the EHR Incentive Program, Maintenance of Certification, ACO, as well as the Value-based Payment Modifier. So – we do encourage EPs to participate now to gain experience in reporting PQRS measures to avoid future adjustments.

So, individual EPs still do have time to participate in 2014 PQRS, and they can do this through the following reporting mechanisms. They can use the qualified registry, they can use a QCDR. They can use Certified EHR Technology or CEHRT EHR Direct, or an EHR Data Submission Vendor that is CEHRT.

Submission Information

Moving on to slide nine, we will go over again some general submission information for 2014 PQRS. So on slide nine, we have the timeline for the 2014 PQRS submissions and we have this displayed by reporting mechanism. So, for CEHRT EHR Direct Product, for CEHRT EHR Data Submission Vendor, and for the QCDR, EHR Incentive Program, all of those methods are going to start – your submission is going to start January – did start January 1st, 2015, and they will end on February 28th, 2015. And all of these – these options, the date – the February 28th deadline is – we have that for alignment with the Meaningful Use, the EHR Incentive Program purposes, so that is an important deadline that we do need to hold to for multiple programs.

The remaining reporting mechanism – so, the QCDR is for PQRS data only, the MOC Incentive Program, Qualified Registry. Those submission timeframes are January 1st, 2015, through March 31st, 2015. And their last mechanism, which is the GPRO web interface, slightly different dates on that one, submission for that will open on January 26th, 2015, and will close March 20th, 2015.

Moving on to slide 10 where – on this slide, we'll briefly touch on IACS or the Individuals Authorized Access to CMS Computer Services. So an IACS account is required for most of the data submission portlets, so that would be for you Qualified Registry, for the QCDR, the GPRO web interface, as well as for CEHRT through either Direct EHR or using a Data Submission Vendor for EHR CEHRT. We do have some quick reference guides on the PQRS website. On slide 10, we do have that link for those IACS reference guides.

OK. Moving on to slide 12, continuing our discussion of PQRS, general PQRS submission. So in terms of testing, we do strongly encourage that all entities, whether you're a qualified registry, a QCDR, a Maintenance of Certification or EHR vendor, we do encourage that you submit a test file early to assist in alleviating any issues that may occur during the production submission.

So, we will have these entities. We'll use the Submission Engine Validation Tool or SEVT through the physician and other health care professionals quality reporting portal which we also – that's a mouthful. So we also just refer to that as the PQRS portal for test submissions. And the PQRS for the actual production submission, that is located on the

PQRS portal. So on slide 12, we do have the link there for the PQRS portal where you will find the – your – the application for your submission.

Reporting Mechanism

OK, so let's go ahead and move on to discuss each specific reporting mechanism. So on slide 14, for 2014 Qualified Registry. So the qualified registries must aggregate their measures and calculate the data on behalf of their EPs. They must collect all needed data elements and transmit the data to CMS in the CMS-approved Qualified Registry XML, and also use the CMS-approved Qualified Registry XML format. And the specifications for the Registry XML are available on the Registry Reporting web page of the PQRS website. Again on slide 14, we have that link – if you are on the PQRS website, you would want to go to the Registry Reporting page to find those XML specifications.

Moving on to slide 15. Each of the XML files is limited to a single submission method. So what this means is we —we have—registries can be submitted for individual Eps. Registries can also submit for a group practice. However, those will need to be separate files, so we would be looking for one file that contains data for individual EPs only, and you can't combine – we don't want the combination of data for both individual EPs and group practices in one file. So, one XML file will need to be submitted for each of the submission methods.

And only 2014 PQRS registry measures are able to be submitted. So, we should have that. Registry should be checking to make sure that they're using the 2014 measures and check the 2014 measure specifications, which again are located on our CMS PQRS website, on the Measures Codes page. And we do have that link, again, on slide 15.

Moving on to slide 16, continuing our discussion on Qualified Registry Submission. The collection of the data can be done either through EHR, through claims, practice management system, or a type of web-based tool. That's really up to the vendor and the EP that they're working with on how that is going to be done. The individual EP data must include the individual NPI or National Provider Identifier of the EP. A group NPI must not be submitted. So we're really looking for the individual NPI in those files.

However, on the other hand, if you are submitting the group practice, the GPRO data, the NPI value must not be submitted. So this will help us distinguish between what's – what's individual level data versus what is group data of individual level. We will need to have that NPI, whereas the group data is aggregated at the TIN level for the group practices who have elected to report via GPRO. And a group practice again must have registered to report via a qualified registry under the GPRO for 2014 PQRS.

Moving on to slide 17. A qualified registry will provide instructions on how and when to submit the data. So again, the EPs will be working with that registry on the information on – each qualified registry must have an IACS account to submit test and production data – and confirming that the data was submitted is definitely an important step. So EP

should be working directly with the qualified registry to make sure the data is submitted appropriately by the data submission deadline.

OK. So now we're going to move on to a different reporting mechanism. We're going to discuss Qualified Clinical Data Registry submissions or QCDRs. So, starting on slide 19. So the data submitted to CMS via QCDR does cover quality measures across multiple payers. So, unlike some of the other reporting mechanism, it is not limited to Medicare beneficiaries. So the QCDRs are responsible for aggregating and calculating measures data on behalf of their EPs. And the QCDRs must be able to collect all the needed data elements and transmit the data to CMS in one of two formats, so that would be the QCDR XML or the QRDA Category 3.

OK, slide 20. The data submission side – there are some data submission restrictions, so the QCDR XML files must be greater than 0 bytes but not exceed 80 megabytes. The QRDA Category 3 must be greater than 0 megabytes but not exceed 10 megabytes. So production files of the same file type may be zipped.

OK, slide 21, continuing our discussion on the 2014 QCDR submission. The QCDR XML, this format must be used when submitting the PQRS-specified measures or QCDR-specified measures for purpose of PQRS participation. So the QCDR XML submissions, again, the deadline for that is March 31st, 2015. So we need to have received your files by that date. The QCDR XML specifications are available, again, on our website. So these are located on the QCDR reporting web page of this PQRS website. Again, I'm on slide 21. So that link is there if you need that.

Regarding the QRDA Category 3 file, so this – the category – the QRDA Category 3 format must only be used when submitting the eCQMs for purposes of PQRS and also the EHR Incentive Program participation. So – and then, of course, as always, you know, please note that the correct version of the eCQM specifications must be used.

And so the QRDA Category 3 submission will be accepted through February 28th, 2015. So please note the difference in the deadlines depending on the type of file that you were submitting. If you were submitting QRDA 3 EHR data, we need to have that by February 28th, 2015. And the QRDA Category 3 specifications are also available on our QCDR web page.

OK. So moving on to the next reporting method – is the EHR-based reporting. So we can pick up on slide 23 for that. So your EHR will need to be considered CEHRT. EHR Direct, that is CERHT is a vendor who certified an EHR product and version for EPs to utilize directly – to directly submit their PQRS data. And this does require an IACS account.

And this is distinguished from an EHR data submission vendor that is CEHRT. An EHR data submission vendor is a vendor who submits measure data on an EP's behalf. They'll collect an EP's clinical quality data directly from the EP's EHR system, and then the

vendor will be responsible for submitting PQRS measure data from an EP's EHR system to CMS in the CMS-specified format.

So on slide 24….

Female: I am on it. Do you want the number I have?

Aryeh Langer: Excuse me can you please mute your line?

Lauren Fuentes: Sorry about that. So on slide 24, EHR vendors that are submitting PQRS data will only need to submit one file format. So you're – we're either looking for the QRDA Category 1, this is patient level, or Category 3 aggregate. So EHR vendors submitting the PQRS GPRO data on behalf of a group practice must aggregate the data at the TIN level to ensure that the data is calculated correctly for group practice reporting.

So QRDA 1 and QRDA 3 submissions should represent the patient as seen by the TIN, not the individual NPIs within the TIN. Therefore, for those measures that require two or more encounters, the EHR vendor should take into account encounters from all of the NPIs under that specific TIN.

So – and the QRDA specifications, again, are available on our website on the Clinical Quality Measure web page of the EHR Incentive Program. So again, I'm on slide 24, and we do have a link where you can find the eCQMs on that slide.

OK, slide 25, continuing our discussion about EHR-based reporting for 2014. EPs and group practices must submit the final set of data via 2014 CEHRT.

So, all EPs within a group practice participating through the GPRO must be using CEHRT to be eligible for PQRS reporting via EHR. And again a group practice must have registered to report via EHR under the 2014 PQRS GPRO in order for their EHR data submission to count for PQRS. If that registration system tells CMS how you plan to report and that is the way you will be assessed. So you do need to be consistent with how you registered for 2014 if you registered as a GPRO.

OK, so moving on to slide 26 for continuing on 2014 EHR-based reporting methods, your EP should be working with their EHR vendor to create the required reporting file from their EHR systems so they can be uploaded through the PQRS portal using IACS. It's important again to confirm that your data was submitted – submit your final EHR reporting files with quality measures data or ensure your data submission vendor has submitted your files by the data submission deadline.

OK, slide 27. EHR vendors do not need to submit all NPIs within the group practices. So for purposes of the Medicare EHR Incentive Program, CMS will determine which NPI

satisfactorily reported within a group practice. If an EP or group practice changes TINs participation, the old TIN does not carry over to the new TIN, nor is it combined for final analysis.

OK, slide 26. So the data submission vendors must enter into and maintain with the participating professionals and appropriate Business Associate Agreement, group practices who registered to participate in the PQRS GPRO reporting through the EHR Direct, or a Data Submission Vendor will need to be analyzed at the TIN level.

OK, moving on to our next reporting mechanism. Now we're going to switch gears a little bit and discuss the ACO and PQRS GPRO web interface. So I'm on slide 30. Now, so the 2014 GPRO web interface submission is used by PQRS group practices. And it's also used by ACOs. So the group practices reporting via GPRO with 25 or more EPs and that group may participate via the web interface. A group practice reporting via GPRO must have registered to report via the GPRO web interface during the 2014 GPRO registration period.

So this is again just a reminder of the – how we discussed before that when you do register a report, you know, that the method that you select during that time is the way that CMS will be expecting you to report and will be analyzing you that way. The GPRO web interface reporting is available for group practices, as I said before, for either PQRS GPRO or Accountable Care Organizations or ACOs. And the measure specifications and supporting documents for the web interface are located on our – on the GPRO web interface page. And I do have that link available for you on slide 30.

OK, slide 31, continuing our discussion on 2014 GPRO web interface submission. The GPRO interface is updated each year based on PQRS program needs as well as user feedback updates for the 2014 GPRO web interface and include pull-down menus on the measure tabs and include a blank option to erase a previously entered answer. The user's name appears on–off screens and reports instead of their IACS ID. And there's also a new comments reports. So the CARE and PREV comments are separate on the screen and in the report. And comments are limited to 140 characters.

OK, slide 32. The group practices that satisfactorily report through the GPRO web interface may also satisfy the eCQM component of the Medicare EHR Incentive Program. So EPs that wish to satisfy the eCQM component will need to use CEHRT 2014 edition to collect data for their GPRO web interface.

OK, slide 33. We're now moving on to discussing the Maintenance of Certification Program. OK and slide 34, individual EPs – so the Maintenance of Certification is another incentive available to individual EPs who earn the PQRS incentive. And then if they meet the requirements for the Maintenance of Certification or MOC Program, they are eligible for an additional incentive of 0.5 percent by working with a maintenance of certification entity.

So, data is submitted for the individual EP by the Maintenance of Certification Program. And a MOC entity should submit their data using the Maintenance of Certification Program XML specification for PQRS program participation.

OK. And we do have that link for you on slide 34 to where the specifications are located, but they are located on the PQRS website on the Maintenance of Certification web page.

OK, so that concludes our presentation for today.

Resources

On slide 36, we have a list of resources for you including, you know, we mention the PQRS website a number of times, so that link is there for you as well as links to the other programs—the Medicare Shared Savings Program as well as the Value-based Payment Modifier website—those links are also provided for you.

On slide 37, who to call for help. I mentioned the QualityNet Help Desk earlier, and they're really the people to call when you have – if you're having any issues with your IACS account, with your submissions, you will be directed to the QualityNet Help Desk. So that information is provided there, as well as a few other help desks and call centers for you depending on which program you're trying to find information about. That information is available on slide 37.

OK, so I think we're ready. I'll turn it over to Aryeh and we can get started with questions and answers.

Physician Compare Program

Sure, hi, this is Ashley Spence. I'm also from the PQRS team. And we just wanted to give you a few announcements from our Physician Compare Program here at CMS. So CMS is currently evaluating options for publicly reported benchmark for Physician Compare – for the Physician Compare website.

As noted in the 2015 physician's fee-schedule final rule, CMS wants to discuss more thoroughly potential benchmarking methodologies with our stakeholders prior to finalizing future proposals. CMS also wants to evaluate other program methodologies, including Shared-Savings Program and Value-Modifier, to work toward better alignment across programs.

CMS is interested in hearing from stakeholders regarding these potential benchmarking approaches, as well as suggestions on ultimate benchmarking methodologies for Physician Compare.

So we're asking that all suggestions be sent to a Physician Compare web—sorry—email box, and that is physiciancompare@westat.com. So that's physiciancompare@W-E-S-T-A-T.com.

When you submit your suggestions, you'll receive a response confirming that your message was received. Please feel free to share the mailbox address and – because it is public, and all suggestions should be received by Tuesday, March the 3rd, 2015.

One final announcement, also from Physician Compare. Physician Compare is hosting a virtual office hour session on January 22nd, 2015. Discussion will provide CMS an opportunity to directly address questions about Physician Compare and public reporting. This session is a WebEx, and it will be held from 11:30 a.m. to 12:30 p.m. eastern time.

You can also register for this session using the same email box provided, which is physiciancompare@westat.com. When you are registering for this session, we just ask that you include Physician Compare virtual office hour in the subject and include your name, organization, telephone number, and the best email for contact.

We're also asking that questions for this webinar be solicited in advance. So in that email, if you can include your questions with your registration information, that would be appreciated. All questions should be received by 5 p.m. eastern time on Wednesday, January 14th. Thank you.

Aryeh Langer: Thank you Ashley. We're going to actually post that information on the website that I mentioned at the beginning of the call so everybody who's listening and those folks who will listen to the audio version of this can actually find that information after the call. So you can look for that in the coming days on the, again, on the website I've mentioned before.

Keypad Polling

Aryeh Langer: Before moving to the question-and-answer portion of the call, we'll pause for a moment to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today.

Please note, there will be silence on the line while we tabulate the results. Salema, we're ready to start the polling, please.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone 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. If there are nine or more of you in the room, enter nine.

Once 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. 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. Thank you for your participation. I'd now like to turn the call back over to Aryeh Langer.

Question-and-Answer Session

Aryeh Langer: Thank you Salema. Our subject matter experts here at CMS will now take your questions. As this call is being recorded and transcribed, please state your name and the name of your organization before asking your questions. In an effort to hear from as many callers as possible, we also ask that you limit yourself to one question at a time.

If you have more than one question, please press star one after the question was answered to get back in the queue and we'll address additional questions as time permits. Salema, we're ready to take our first question, please.

Operator: 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. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything that you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Operator: The first question comes from the line of Christine Demez. Christine, your line is open.

Christine Demez: Hello. Hello. Hello, are you there?

Aryeh Langer: Yes, hello.

Christine Demez: Hey, how are you? I was hoping I'd be number 20 in the queue. I'm coming from Rhode Island Medical Imaging. We are a new GPRO, and there are three of us in the office trying to understand what we're supposed to be doing with all of this testing stuff that we're doing since the beginning of the month.

And if you could just clarify for me the patient file that I downloaded this week, the anonymous one. That is a test file that – does that represent what we're actually going to get from CMS? And I'm confused because I can't manipulate this file. I can't do anything with it. Again, is this just because I need to familiarize myself with it?

Lauren Fuentes: Hi Christine, this is Lauren Fuentes. So I think, you know, I'm assuming you're – it sounds like you're participating in GPRO web interface, correct?

Christine Demez: Yes.

Lauren Fuentes: So we actually have calls or are having calls on that particular mechanism that I think would probably be a better place to get your questions addressed.

So I'm not sure when. I think we have a call Thursday, there's a Q&A call so, you know, I think if you can hold your question for at that time, I think that would be a much better place.

Christine Demez: OK. I'll do that.

Lauren Fuentes: OK.

Christine Demez: Thank you.

Operator: The next question comes from the line of Nancy Lambert. Nancy, your line is open.

Nancy Lambert: Yes, we have our – EHR has not been certified for 2014 as of yet, but I have reported all the information to QualityNet with the 2013 certification for the 2014 charges. Is this why everything is getting rejected from QualityNet?

Lauren Fuentes: Hi, this is Lauren. So I'm, you know, to work through your specific issue on why it's being rejected—unfortunately, no, I am going to have to send you back to QualityNet desk, just because I can't address at this time what your specific issues are.

Nancy Lambert: OK, but do we have to be on 2014 certified?

Lauren Fuentes: Yes, thank you.

Nancy Lambert: Who submitted, and if I'm going to – using 2013, could that be one of the problems?

Lauren Fuentes: I think so. I mean, the requirement is that you must be certified for 2014.

Nancy Lambert: OK. I've already got – I've – QualityNet is already working on this. It's been ongoing for over a week, a week and half.

Lauren Fuentes: OK.

Nancy Lambert: OK, thank you.

Lauren Fuentes: All right, thanks.

Nancy Lambert: Bye-bye.

Operator: Our next question comes from the line of Jen Lucore.

Jen Lucore: Hi, I'm calling on behalf of a small company that manages four ambulatory surgery centers in Illinois. We were told back in September by customer service and a team lead at National Government Services that our anesthesiologists were not considered eligible providers because their services are payable under fee schedules or methodologies other than the physician fee schedule. And I'm specifically referring to something from the PQRS website, PDF list of eligible professionals.

It says services are excluded, those provided in and blah, blah, independent diagnostic help testing facility, et cetera, and ambulatory surgery center facilities. And they're paid under that anesthesia fee schedule. So I'm just calling to confirm that they are not considered eligible providers, because one of them got a letter.

Lauren Fuentes: Yes, I'm familiar with what you're referencing. And really the nuance here with in terms of who's eligible is – if you're not billing, you know, physician fee schedule Part B, then no, then they wouldn't be eligible. But that's really the key. And how PQRS payment adjustment works is we have our list of EPs. So, you know, to your point, I mean if your ambulatory surgery centers are billing under something other than the physician fee schedule….

But if you got a letter, most likely there were some charges than came through for Part B PFS. So what you can do is go ahead and submit an informal review. Right now, we have an informal review process that covers 2013 reporting. So that will be for either your 2013 PQRS incentive or 2015 PQRS payment adjustment. So I think that would be the best course of action for you, and then we can actually review that case and see what that provider is billing.

But if they're billing Part B under the PFS for services that, you know, due or eligible that appear under PQRS monitors and, yes, they would be subject to the PQRS payment adjustment.

Jen Lucore: Even though if – or it says services under fee schedules other than – well, if the anesthesia…

Lauren Fuentes: OK.

Jen Lucore: … physician fee schedule. And it says… OK, and ambulatory surgery centers. So the answer is services provided in ambulatory surgery centers are excluded?

Molly MacHarris: Hi, this is Molly. So what Lauren is saying is that for that provider that you received the letter for, we, over here at CMS found some Part B charges associated with that provider. So if you believe that to be incorrect, you can file an informal review, which that period is open now, you have until February 28 to do that. It's a low burden process. You just have to fill out a form and we'll look at this specific case for this specific TIN and NPI that's called out in the letter, but…

Jen Lucore: OK.

Molly MacHarris: So that's what you can do and we can look into, but that's why you received the letter. It's because we did find Part B charges for that specific TIN and the NPI that was called out in the letter.

Jen Lucore: And where do I file that informal review? How do I go about that?

Lauren Fuentes: If you go in our PQRS website that Aryeh mentioned, there is a link over there under our analysis and payment section to the actual form that you would go on, and there's also a guide that will kind of give you step-by-step instruction as to how to submit an informal review.

Jen Lucore: OK.

Lauren Fuentes: Thank you.

Jen Lucore: Thanks.

Operator: Our next question comes from the line of Ally Carino.

Ally Carino: Hello?

Aryeh Langer: Hello, go ahead please.

Ally Carino: Hi. Excuse me, I am losing my voice. I am questioning this EHR base reporting methods. Am I correct on understanding the EHR direct needs to be the certified, but then you would download a format, this file formats, the QRDA categories, in order to submit your data to CMS?

Molly MacHarris: Hi. This is Molly. So I think you're referencing the QRDA file format, so that refers to quality reporting document architecture. And there are two separate ones: QRDA, I which is a patient level file, or QRDA III, which is an aggregate file. But if you're reporting using an EHR, the first thing you would want to do is make sure that your EHR is considered certified EHR technology, the 2014 edition.

And then next you would need to work with your EHR vendor to determine if it would make most sense for your practice to – for you to submit the information to CMS directly or using a data submission vendor.

And in that – that conversation that you have with your EHR vendor, you would want to work with them to determine whether or not the QRDA I file format or the QRDA III file format would make most – would make the most sense. Either one is acceptable for PQRS. It just really depends on what your preferences are for your practice.

Ally Carino: Thank you.

Operator: The next question comes from the line of Darlene Pickable.

Darlene Pickable: Hello.

Operator: Darlene, your line is open.

Darlene Pickable: If we're submit – hi, if we're submitting data through a claim-base reporting, how do we see those results? Is there a website to go to to see the result for the individual EPs that we've reported on throughout the year?

Molly MacHarris: So there are two ways. You mentioned a website. We do have an interim feedback dashboard, which is based on claims reporting. So you can access that and it will show you what is being reported. And then another way, you know, more manual way, is if you look at your remittance advices, you will receive a code that will indicate to you, it's the – N620 I think is the code.

I'm sorry, just off the top of my head, I'm not recalling exactly what that code is, but there is a code that will say, you know, this service is not payable. It's for quality reporting purposes only. So that's another way that will, you know, at least let you know that CMS did receive your quality data code.

Darlene Pickable: The first way was what though? Where would you go online to look at it?

Molly MacHarris: It's a dashboard. You have to go to the physician, the PQRS portal. And we do have that link. I don't know if you have the slides but, you know, we do have a

link to our website. So if you were on our – if you went to our website you can go to…. So on slide 36 if you go to the resources and you go to our website and if you look at the analysis and payment page, there will be information on how to access that dashboard.

Darlene Pickable: OK, thank you.

Molly MacHarris: You're welcome.

Operator: Your next question comes from the line of Sherryle Givens.

Sherryle Givens: Hi, I'm calling on behalf of a two-hospital organization who bills under the same TIN, specifically anesthesia and emergency room physicians. We are doing registry reporting for them. But here's my problem. We have – I have scoured CMS's website and I'm actually going to refer now to your slide 45 where it talks about summary of requirements for avoiding the adjustment. And the last at the bottom of the page, it's the qualified registry, individual measures. And it talks about if there are fewer than nine measures that are applicable to your specialty, that once those measures that are reported get to CMS, they will do the MAV process.

When I look at the flow process flow chart for the MAV process and when I access the training there's like PowerPoint training that you have online about the MAV process. But it's there in black and white saying that it all comes down to clinical clusters. So that if you reported for example an anest – an ED measure on the 12-lead EKG for syncope, in that cluster is also the measure for a 12-lead EKG for a nontrauma chest pain.

The flow chart then suggests that as long as you reported that all measures within that related cluster, then you would be deemed as having met, you know, passing the MAV process. When I call the QNET Help Desk, their answer is completely different. And they tell me that, No. They may look for other things to see if you could have reported this, if you could have reported that, but again that's not what I'm finding in black and white, that's not what the registry or certified registry rep is telling me.

So I just wanted some guidance on that because that will be a huge difference in whether they are penalized or not.

Sophia Autrey: Hello. This is Sophia Autrey with CMS, and you are correct. If there is a specialty and that specialty or EP is actually reporting measures that are less than nine measures or at less than three domains, that it will go through the MAV process and if it identifies a clinical cluster and you actually report on all of the measures that are within that clinical cluster, then you will pass MAV. So you are correct.

Sherryle Givens: Thank you.

Sophia Autrey: You're welcome.

Operator: The next question comes from the line of Eudira Megana.

Eudira Megana: Actually my question has been answered. Thank you.

Operator: The next question comes from the line of Dennis Mayan.

Dennis Mayan: Yes, my question has been answered too. Thank you.

Operator: And the next question comes from the line of Maria Buss.

Maria Buss: Yes, hi. Good afternoon. I'm representing a clinic that is both a gastroenterology specialty – excuse me, and cardiology. My question has to do with the MOPC. If you can tell me whether the MOCP – rather the Maintenance of Certification Program –is that a separate entity from the qualified registry or the EHR vendor?

Molly MacHarris: Hi. This is Molly. So yes, the MOC Program, the Maintenance of Certification Program, is actually a completely separate additional incentive that you can earn on top of the PQRS program. So it's completely separate from qualified registry or EHR, which are considered reporting mechanisms under PQRS. The way that the Maintenance of Certification Program works is, in 2014 is the last year.

And to be able to earn that, first, you would have to earn the PQRS incentive, then additionally you would have to more frequently than required participate in your Medicare of or – sorry, Maintenance of Certification Program through one of the Maintenance of Certification Program boards that has been qualified.

We do have a list of those available on our website if you have questions on that, too.

Maria Buss: That was my question. You know, so you have a list of all those entities and the other requirements to be able to maintain and be certified, you know, that kind of info. You answered my questions. Thank you so much.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Stephanie Williamson.

Stephanie Williamson: Hi. I'm calling from a solo orthopedic office. Medicare is a very small part of his practice, less than 5 percent. And so for the measure groups, there are really only two that we would see patients for but we don't have enough patients to even qualify for the 20 individual unique patients that are required for the review. So would we go through the MAV process at that point? How does that work?

Sophia Autrey: So I guess the issue would be – well the first question would be, are there measures that you can report individually other than the measures group?

Because you would need to report other than measures that are provided other than the measures group in order to be able to report. Did I answer your question?

Stephanie Williamson: No, I'm sorry. I don't understand what that means.

Sophia Autrey: OK, so the requirement for the measures group would be that you have at least or minimum of 20 participants. And since you don't have 20 participants, you would need to find another reporting option, meaning claims, registry, or EHR to report measures. So the measures group would not be a – you would not be able to report for the measures group if you have less than 20 participants.

Stephanie Williamson: OK. All right, thank you.

Sophia Autrey: You're welcome.

Operator: Your next question comes from the line of Janet Walker. Janet, your line is open.

Janet Walker: Hi. We're a new practice and just have been seeing patients for less than 6 months, and so trying to scramble at the last minute to understand all this. I just registered for my IACS number yesterday. What do I do next while we're waiting for the account to be approved?

Lauren Fuentes: Hi. So I mean at this point, yes, you'll need to wait. What method are you reporting?

Janet Walker: Well, we're not sure what a qualified vendor –so – a data submission vendor is or it'll be through our EHR.

Lauren Fuentes: OK, so you're definitely going to be using the EHR reporting. I mean the difference between those two is, you know, you can either submit your data directly through your EHR products with your vendor or you can use a data submission vendor, which they pretty much submit on your behalf.

Janet Walker: OK.

Lauren Fuentes: So that's the difference between those two. So I mean, at this point I – do you have a vendor?

Janet Walker: No, no, we got a certified EHR.

Lauren Fuentes: OK. OK, so if you're going to plan to submit that way…

Janet Walker: Should it be the…

Lauren Fuentes: Yes, you can still work with your EHR, your vendor, your representative. If I'm assuming you have a contact.

Janet Walker: Yes, they've not been very helpful up to this point.

Lauren Fuentes: OK. Well, that's disappointing. But I mean, that's really, you know, we encourage you to work with your vendor to make sure that your data is going to be submitted properly.

Janet Walker: OK. So do we – should we just be just picking out what our majors are? Because we're behavioral health and I – from what I understand, it's hard to find the three-by-three measures.

Molly MacHarris: This is Molly. One of the things I might recommend that you do, and I don't mean to say, you know, to put you off. But you may want to contact the QualityNet Help Desk just because they would be able to go into detail with you for your particular practice and which measures will, you know, be the most beneficial for you and then which reporting mechanism.

One of the things you're going to want to keep in mind is that if your practice began about 6 months ago, you are going to want to work on your 2014 reporting, which the data for that or the submission of that was a subject of this call, and you would need to get that into CMS in the next couple of months or potentially you could have a 2016 payment adjustment. But since we are in January 2015, it's actually the beginning of the 2015 PQRS reporting period as well, which would apply for the 2017 payment adjustment. And…

Janet Walker: Right.

Molly MacHarris: … so with all that being said, the QualityNet Help Desk, they can go over with you the various measures and reporting mechanisms to find which measures and which mechanism will make the most sense for you.

Janet Walker: All right, thank you so much.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Mohammed Maseen. Mohammed, your line is open.

Mohammed Maseen: Hi. We are a certified EHR for 2014 edition. And, you know, this is our first year and we are trying to help our clients submit PQRS data. So what is the

actual process for us to do that? Should we create an IACS account and submit on behalf of each EP? Or how do we do that?

Molly MacHarris: Hi. This is Molly. So we do have some stuff available on our website on – it's the cms.gov PQRS site under EHR. There are sections there that call out EHR reporting for vendors and there are some step-by-step guides. Additionally there is going to be a call held on Thursday. It's an eHealth call which will be specific to EHR vendors. And that call might actually be more beneficial for you because that call is targeted to EHR vendors.

And there will be additional subject matter expert who can address the steps involved in actually submitting your data to the PQRS system.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Antonia Romero.

Antonia Romero: Hello.

Aryeh Langer: Hello.

Antonia Romero: My question – hi. My question is, are we qualified for the Medicare as an EP? It's only one EP that we have here, the eligible provider. We have five PAs that work under him. How does the PQRS come in place? I was told that we don't qualify, that the one to qualify will be as a group. But we're not considered a group.

Molly MacHarris: Hi. This is Molly. So just to clarify under PQRS physician assistants are included as eligible professionals. So I think – I thought I heard you say that you only had one eligible professional, but then you have five physician assistants. So just to clarify, the physician assistants are included under PQRS.

Antonia Romero: They are? OK.

Molly MacHarris: And it sounds like you're just trying to figure out how to get started at PQRS, is that right?

Antonia Romero: Yes, yes.

Molly MacHarris: So similar to some of the other callers that have come in, we recommend that you reach out to the QualityNet Help Desk, because they can help you with getting started. Additionally, you could look at some of the material we have on our website. There's a lot of documents that are, you know, kind of how to get started, what's new for 2015 to – and that would be another great resource.

Antonia Romero: OK. Thank you.

Molly MacHarris: Thank you.

Aryeh Langer: If I could just remind callers to please state their name. Thank you.

Operator: The next question comes from the line of Bobbi McAllister.

Bobbi McAllister: Hi. This is Bobbi McAllister from Rehabilitation Medicine Associates. I registered for GPRO back in October. And I honestly cannot recall what I selected at that time. I'm concerned that I indicated that I would be using our certified EHR. And my vendor has since then told me that they would not be supporting that for us. So it – my first question is, how can I check to see how I registered? And then my second question is, can I change that if I need to?

Lauren Fuentes: Hi Bobbi. This is Lauren Fuentes. So your first question on how you can check, you should have gotten a confirmation email. But, you know, certainly I understand a lot of time has gone by. So you may not have that. So what you can do is you can call the physician value PQRS Help Desk. So let me see, I'm just checking our resources real quick to see. So on slide 37 we do have that information for you. So you can contact them and they'll be able to tell you what you've registered for.

And, unfortunately, you know, at this time we cannot change any mechanism, reporting mechanisms. And we're just too far into the process of 2014 submission to that point. So if you do find it – that it's something that your vendor is not going to support, I would encourage you to go ahead and try and submit any way you can. So if that be, you know, through the individual EP method, I would do that and then we may have to address any subsequent issues with, you know, not reporting on via your selected method through the informal review process for 2014 reporting.

Bobbi McAllister: That's unfortunate. OK. Well, thank you very much. I appreciate that.

Lauren Fuentes: All right, thank you.

Operator: Our next question is from Corina Ricebeck.

Corina Ricebeck: Hi. My name is Corina. I'm calling from a small neurosurgery clinic. We are using two 2014-certified EHR. And I need to know, does the electronic clinical measures meet PQRS requirements? I think I heard you say the opposite, that PQRS can meet the eCQM measurements. But is vice-versa also true?

Lauren Fuentes: Yes. Hi. So yes, they're the same measures. So it works both ways. I mean, PQRS, we are – we accept the eCQM and that's how you will submit your data for the EHR incentive program. So it's one and the same.

Corina Ricebeck: I'm getting – because I'm getting some contradictory information from our EHR.

Lauren Fuentes: OK.

Corina Ricebeck: We meet the requirements, everything is there, but they're telling me the only way we can submit – and they just told me it a week ago, once we're already into 2015, the only way we meet the requirement is that we would have had to report on individual claims all year long last year, which we didn't know until now. And now, you guys are saying we can't report that way any longer.

Lauren Fuentes: Yes, that doesn't make a whole lot of sense to us in the room. I mean, really what happens with the EHR reporting is they'll collect all that data that, you know, on the services that you have provided in 2014 and then that data will be submitted in a file, the –you know, we talked about the file – the different file formats earlier in the presentation, and that file based on your 2014 services that you provided needs to be submitted to CMS by February 28, 2015.

Corina Ricebeck: Right. And it's the e-clinical measures that – and…

Lauren Fuentes: Yes.

Corina Ricebeck: … the same type of measures we have to upload to meet the EHR incentive?

Female: Yes, it's the same – they're the same measures, yes.

Corina Ricebeck: Yes.

Lauren Fuentes: It's the same measure.

Corina Ricebeck: So how can I get clarification with them? Because they keep telling me No. And I have actually a PowerPoint presentation from them that says the only way we can submit is individual claimable.

Molly MacHarris: So – this is Molly. One other thing that you could do, because I mean we'd be interested to hear which vendor is saying this so we can educate them that that's not correct. If you want to send that information over to the QualityNet Help Desk, and put in the subject heading of the email that it was requested by CMS on today's national provider call. They will make sure that that information gets over to us and we address that with the vendor directly.

But as Lauren stated, e-Reporting of the eCQM is the same eCQMs that you would be reporting from meaningful use will apply for PQRS. You don't have to report via claims if you don't want to.

The only thing that I could think of that they may be speaking of is that under the meaningful use programs there is an option to attest to your eCQMs, and that does not apply for PQRS. But if you are e-Reporting your eCQMs where the actual data gets uploaded…

Corina Ricebeck: Uploaded?

Molly MacHarris: … that does apply.

Corina Ricebeck: Yes. And they walked me through how to upload it and everything.

Molly MacHarris: Yes. So we'll be really interested to know which vendor – I mean, unless you want to tell us now, but I mean, that's fine if you don't have…

Corina Ricebeck: I have no problem. It's MicroMD, I am furious. Because we did the work all year long and now we're getting letters saying – the last 2 years, we did it in 2013 also. And now they're saying, "We don't need it. We've gotten the letters from you guys." And they just told us last week that we won't need it for 2014 either.

Molly MacHarris: OK, well that – that's really helpful to know. So if you do want to still go ahead and send us over that PowerPoint presentation to our help desk and we can take a look at it. We'll reach out to them and educate them that that's not correct. So thank you for bringing this to our attention.

Corina Ricebeck: And I will be – yes, contacting them today also, again. Thank you.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Sheila Banyai.

Sheila Banyai: Hi. You've answered my questions.

Operator: The next question comes from the line of Denise Blahead.

Denise Blahead: Yes, I'm calling – we're working and have been working since November 20th on our revalidation with Medicare. And I'm just wondering, we're ready to attest for Stage 2 for 2014. Is there any common link that's going to run interference with our revalidation in our attestation for meaningful use?

Lauren Fuentes: So hi. Do we have anyone from the EHR incentive program that can answer that question on the line?

Vidya Sellappan: And hi. This is Vidya. Can you repeat the question one more time?

Denise Blankenship: So we have been working on our revalidation with Medicare since November 20th. It's not complete. There was problems with the NPI, it wasn't connected with – just a lot of connections that weren't made. And so we're now ready to attest to meaningful use Stage 1, under the flexible rule. And before I start that I want to make sure that there is no common link between revalidating and attesting for EHR.

Vidya Sellappan: So do you have – have you talked to the EHR Help Desk yet about the scenario?

Denise Blankenship: I have not.

Vidya Sellappan: OK.

Denise Blankenship: No, I have not.

Vidya Sellappan: It may be helpful to give them all your specifics to make sure the things are OK.

Denise Blankenship: OK. It's interesting and it's a whole revalidation process. I've talked to probably five to eight different people. And everyone gives me a different answer. That's why this process is taking from November to now. Maybe they (inaudible) different answer, they need different…

Vidya Sellappan: Whoever is moderating can, of course, can provide an email address that maybe you can respond to and then maybe I can take this offline and do a little research and find out what's going on.

Denise Blankenship: OK. So what are you asking, that I just get somebody's email address and communicate with them via that avenue?

Aryeh Langer: If you want to send an email in, I can give you my email address. It's aryeh.langer@cms.hhs.gov.

Denise Blankenship: OK, I got the……

Aryeh Langer: And I will take care of that for you.

Denise Blankenship: I got that @cms., what was the rest?

Aryeh Langer: hhs.gov.

Denise Blankenship: OK, I have aryeh.langer@cms.hhs.gov

Aryeh Langer: Right.

Denise Blankenship: Is that correct?

Aryeh Langer: Yes.

Denise Blankenship: OK.

Vidya Sellappan: So…

Denise Blankenship: All right, so I'm just going to send you my question and have you respond for what I send you.

Aryeh Langer: And we'll take care of that for you once we get it.

Denise Blankenship: That would be great. Thank you very much.

Operator: The next question comes from the line of Maricel Prosema.

Maricel Puriscima: Hi. This is Maricel, and I represent a gastroenterology office. My question is for the past 3 years we have been reporting through her-base reporting. And I received letters from —I am trying to find out because we have successfully reported for the past 3 years. And I'm trying to understand why we're receiving letters because they have been received and…

Aryeh Langer: I'm sorry, can you start over? We're having a hard time hearing you.

Maricel Puriscima: I'm sorry.

Aryeh Langer: Thank you.

Maricel Puriscima: OK, let me start over. OK. We have been submitting our PQRS through EHR-based reporting. And I'm trying to figure out because we have received letters for our providers and I'm trying to figure out – for the past 3 years, we have been reporting successfully. And it's stating that we didn't meet the criteria. And I'm trying to understand why and if we were supposed to submit in a different manner.

Lauren Fuentes: So hi. So if, you know, it sounds like you received, you know, notification that some of your providers are subject to the 2015 payment adjustment, is that correct?

Maricel Puriscima: Yes.

Lauren Fuentes: And so is this – was this for the PQRS program or for the EHR incentive? PQRS, OK. So what would really be the best situation? You know, if you believe this is inaccurate, which, you know, it sounds like you do. If you can go ahead and submit an informal review request to us, then that would help us, you know, we can look at the particular instances and why these NPIs, why these providers are showing up subject to the payment adjustment.

So it's just a form that you have to fill out. And that form is located – the links to that is – well, there's a link on the portal. I'm not sure if you're familiar with the PQRS portal or not, but we do have a link to that under the communication support page, which is in the left hand corner of that – of the portal homepage.

Or you can go to our PQRS website and on the payment and analysis page, there are also resources on how to submit an informal review.

Maricel Puriscima: Sure. So basically we wouldn't have to submit more than one type of PQRS submission, right? We would just choose from the different types of reporting.

Lauren Fuentes: Right, you choose one method, choose your measures that apply, that are reportable through that method, and then you report for all your NPIs. I mean, is it – I mean, I don't know if it's possible that – were you reporting individually or as a group practice?

Maricel Puriscima: It's individually.

Lauren Fuentes: OK. So some of your providers are subject and some are not.

Maricel Puriscima: Yes.

Lauren Fuentes: OK. So yes, I think the best, you know, the best way for us to evaluate this is to have you go ahead and submit the informal review, so we can take a look at this and make it a determination of what happened.

Maricel Puriscima: OK, that's fine. Thank you.

Lauren Fuentes: Thank you.

Operator: For our next question – comes from the line of Laura Piquet. Laura, your line is open.

Laura Piquet: Hi, this is Laura Piquet. I'm from Teton Valley Health Care in Griggs, Idaho. And we just learned that we're responsible to report – or that if we wanted not to get reduction in payment, that is, we needed to report to PQRS.

We're a critical access hospital that runs two rural health clinics. And I was under the impressions from what I've read and what I've been told by QualityNet that the rural health clinics are not required to submit data for PQRS, is that correct?

Aryeh Langer: Give us 1 minute, please, in the room.

Laura Piquet: Pardon?

Aryeh Langer: We're just discussing here in the room.

Laura Piquet: You're discussing that. I mean, I know nobody is required but in order to not get the reduction in payment, I mean.

Lauren Fuentes: OK, so hi. We just touched base on this real quick over here. And so basically, what we have found, I mean, we did discover this, you know, with this, you know, 2015 was the first, you know, application of the payment adjustment.

And what we have discovered is with the rural health clinics, yes, it's true, for the majority of their services, they are not billing Part B physician fee schedule. But what we've learned is that there are certain services that are being billed by the RHC that are under Part B. And those services could be subject to the payment adjustment or there could be another instance where your providers are perhaps working part-time in the rural health centers. And when the letters were sent, I mean, I would, you know, make sure that you take a look at, you know, the tax I.D. number and the National Provider Identifier that is subject. And make sure that does line up with your RHC.

But what we've learned is that, you know, RHCs are – for those services that they bill for Part B, which could be some of those technical components of the services, those are subject to PQRS.

And what you can do at this point, again, you probably heard us tell other callers that, you know, you can go ahead and submit an informal review request. And we can take a look at, you know, what services are being billed that are causing this provider to be subject to the payment adjustment. And the critical access…

Laura Piquet: OK, I believe that we never got any letters to us. We got letters – providers with a different tax I.D. number. And that's how we cross –they've been needing to do this. And we called QualityNet and they said, "Yes, you're," – and anyway, it's been a nightmare ever since.

But we're also a critical access hospital, so what I'm understanding is that they weren't required to report until 2014 either.

Lauren Fuentes: That's correct. Yes, 2014 is correct for the CAH, the billing method two. They can really start reporting in 2014, and they do need to do so to avoid the payment adjustments.

Laura Piquet: OK, but the rural health clinics are they exempt with 2013?

Lauren Fuentes: It depends. I mean, the rural health center is not subject to the PQRS payment adjustment because they don't bill the Part B physician fee schedule but for the services that are being billed by a provider that may be associated with an RHC or if the RHC is—has another kind of component that's billing like physician services under Part B, those services is all – is the key in Part B physician fee schedule, is what is potentially subject to PQRS.

Laura Piquet: OK, thank you.

Lauren Fuentes: So that makes sense?

Laura Piquet: Kind of, I mean, it's just so confusing at this point.

Lauren Fuentes: I know, it's very nuanced. And, I mean, we're working on providing additional guidance, you know, we understand that, you know, this, you know, has probably come as a surprise to some of these entities. And it's a little confusing, so we here at CMS are working on providing some more guidelines and information on this issue.

Laura Piquet: I think the most disheartening part about it is that we wouldn't even have known about it if we hadn't accidentally got somebody else's letters. Then we would have been incurring this reduction in payment without even knowing about it. I mean, we never got a letter from CMS or anything that said, "By the way, heads up, this is coming your way."

Lauren Fuentes: Right, right. No, I understand…..

Laura Piquet: Yes.

Lauren Fuentes: But as I said, you know, will that, you know, this has been brought to our attention and we'll definitely work on providing more guidance.

Laura Piquet: OK, thank you.

Lauren Fuentes: Thank you.

Operator: Our next question comes from the line of Susan Bowles. Susan, your line is open.

Susan Bowles: Hi. This is Susan Bowles. I've listened to the – mostly the anesthesia questions. I'm not really sure if my question got answered, but I'm going to go for it. I do the billing for a small CRNA-only group that works only in ambulatory surgical centers. I've tried to look at all the documentation. I'm not sure what we're supposed to do to keep from getting a cut when we do submit charges on a 1,500. We only use anesthesia codes. We don't deal with any, you know, electronic health records. We don't prescribe – treat patients.

I'm really not sure how this affects us. But each one of the CNRAs got a letter saying, you know, you need this. I don't know exactly what the letter says but we all got one. So they are concerned. I'm calling, I didn't think it involved us whatsoever. But we're one of the qualifying providers. But again, we see one measure and that was a list of anesthesia code in which we do submit three or four of them, because I don't know what we're supposed to do to keep from getting cut.

Aryeh Langer: One moment please.

Susan Bowles: OK.

Molly MacHarris: Hi. This is Molly. So just a clarification on the question you brought forward. So are you actually billing under the physician fee schedule?

Susan Bowles: We're billing under anesthesia fee schedule.

Molly MacHarris: OK. So if you're billing under the anesthesia fee schedule then no, you were not subject to the PQRS program. I think the big key that we would like you and really everyone else on this call to understand if you have a question, if whether or not you are eligible is essentially if you bill one charge, one E/M charge, under the physician fee schedule. That means you are eligible and you are able to participate in PQRS.

If you bill under any other fee schedule, whether that be the institutional side, etc., etc., no, you do not have to participate in PQRS.

Susan Bowles: We've never billed any E/M codes whatsoever being anesthesia ambulatory care center only. So I was curious why we got letters.

Molly MacHarris: So what you can do then, so you received those letters because that means that the specific TIN and NPI, so the Tax Identification Number and the National Provider Identifier that were referenced in the letter, if you look about, I think it's the second paragraph in the letter, it lists that TIN, NPI out. That means that under CMS in 2013 we found at least one Part B charge for that provider.

So what you can do if you feel that's an error, you can submit an informal review request to us over here at CMS and we will take look at that.

Susan Bowles: What am I asking in the informal review? Please review the fact that we're on this list when only billing anesthesia codes?

Molly MacHarris: Essentially yes. You would want to provide that the TIN, NPI that was referenced in the letter, explain your situation and we'll take a look at it. It's not as involved a process as the Medicare review board. You simply just need put the request forward and then we'll start investigating it.

Susan Bowles: OK, I think I understand what happen when we change our brand new software in 2012. There was a little mix up in the starting up on it. And guess what? Some regular CPT codes went out until we got it fixed, when we get denials back.

Molly MacHarris: OK, so with that…

Susan Bowles: And probably what happened. But haven't billed in since then. So I…

Molly MacHarris: So that's probably what happened. And, you know, if you're not actively billing under the physician fee schedule, then the fact that your people would get a penalty out of it. If you're not billing under it, it will be a penalty off of nothing. So it would really be up to you then on whether or not you would want to submit an informal review. Because if you're not billing under the PFS, it might not be worth your time. But just something…

Susan Bowles: But it only happens for – yes, it only happens for about a month and from then on out it's been anesthesia codes.

Molly MacHarris: OK. Well, I hope that helps then.

Susan Bowles: Thank you so much.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Deb Robinson.

Deb Robinson: Hi. This is Deb Robinson. My question is related to individual claim-base reporting. And I wanted to know if an individual EP had the option of billing or reporting by registry, or do they have to report by claim base if that's how they've been doing it for most of the year for 2014?

Aryeh Langer: Could you repeat that; we had trouble hearing you?

Deb Robinson: I'm sorry, that's because I didn't take off the speaker. So if we've – if an individual EP has reported by claim-based for the majority of 2014, do they have to stay claim-based or can they report by a qualified registry?

Lauren Fuentes: So are you – you're wanting to report 2014 data both through claims and QCDR? Is that what you are saying?

Deb Robinson: Yes. For the most of 2014 we've use claim registry – claim-based. That's how we've reported as through claims. But we want to know if we can do it through registry as opposed to claim? We can just send it out to a registry.

Lauren Fuentes: So you can't.

Deb Robinson: Or do we have that option?

Lauren Fuentes: Yes. No, you can – there's no restriction. You can report, you know, via registry as well. I mean what – just so, you know, we're not going to combine your reporting method so, you know, we look at you through claims and then we look at you through registry separately. And then whichever one is, you know, more favorable for you in terms of meeting the reporting requirements, then that's, you know, that data would be used for your PQRS assessment.

Deb Robinson: OK.

Lauren Fuentes: Did that answer your question?

Deb Robinson: That does, that does. Because I was told one way through QualityNet that I could do that and then during one of the national provider calls they said, "No, you could only do it one or the other." So I was trying to nail down the right answer.

Lauren Fuentes: Right. So yes, our—the restriction on, you know, reporting method is, if you report as an individual versus if you're going to report as a group. So…

Deb Robinson: Right.

Lauren Fuentes: …if you're going to report as a group, then you're locked into reporting as a group. But if you've been…

Deb Robinson: Right.

Lauren Fuentes: …reporting individually via claims and now you want to submit individual data through a registry, there you can do that.

Deb Robinson: You can do that. OK. OK, that answers my question. Thank you very much.

Lauren Fuentes: Thank you.

Aryeh Langer: We have time for one final question please.

Operator: And the final question comes from the line of Jill Kennedy. Jill, your line is open.

Jill Kennedy: Hi, we're a hospice with a palliative care program. And we're having a problem meeting criteria for individual measures for our NPs and LCSW due to their scope of practice in our palliative care program. We've contacted your help desk several times and have not gotten any answers, and we are wondering how to proceed for reporting. Do we just submit on any measure that we can? And if we have less than 20 patients to report on, what do we do?

Sophia Autrey: Hi, this is Sophia Autrey, CMS. And so basically because of the limitation of the number of measures that would qualify for your EPs, I would say that they just need to report on the measures that do qualify for them. And it would go through the MAV process.

Jill Kennedy: OK, thank you.

Sophia Autrey: You're welcome.

Additional Information

Aryeh Langer: And unfortunately that's all the time we have for questions today. On slide 40 you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects call experience.

I just want to remind folks on the call that we have resources listed including the CMS PQRS website, which is on slide 36 of today's presentation. And also for callers that we did not get to your question, the QualityNet Help Desk, their information is on slide 37.

Again my name is Aryeh Langer. And I'd like to thank our subject matter experts here at CMS and all our participants who joined us for today's MLN Connects call. Have a great day everybody.

Operator: This concludes today's call. Presenters, please hold.

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