MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Physician Quality Reporting Programs: Reporting Once in 2015
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 the call over to Aryeh Langer. Thank you, you may begin.

Announcements and Introduction

Aryeh Langer: Thank you Victoria. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I'm your moderator today — excuse me, your moderator for today's call.

I would like to welcome you to this MLN Connects National Provider Call on the Physician Quality Reporting System, or PQRS. MLN Connects Calls are part of the Medicare Learning Network.

During today's call, CMS subject matter experts will provide information on how to report once across various 2015 Medicare Quality Reporting Programs, including PQRS, Medicare Electronic Health Record, or EHR, Incentive Program, Value-Based Modifier, or VM, and Medicare Shared Savings Program. A question-and-answer session will follow today's presentation.

Before we get started, I have a couple of announcements. You should have received a link to the slide presentation for today's call in previous registration emails. If you have not already done so, please download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these materials are available.

Finally, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide number 23 of today's presentation for a link to the CE Activity Information and Instructions document.

At this time, I would like to turn the call over to Molly MacHarris from our PQRS area in CMS.

Presentation

Molly MacHarris: Thank you so much, Aryeh, and thank you everyone for joining us today. I'm going to go ahead and get started with the slide presentation, and I will start

on slide 4. So for those of you who have the slides in front of you, if you want to go ahead and move over to slide 4, this covers the agenda and learning objectives for the call.

As Aryeh mentioned, I will be talking about how to report once for the 2015 Medicare Quality Reporting Program, which includes the Physician Quality Reporting System, or PQRS, the Medicare EHR Incentive Program, or the EHR or Meaningful Use Program, the Value-based Payment Modifier, or VM Program, the Medicare Shared Savings Program Accountable Care Organization, and the Pioneer Accountable Care Organization. And that will be broken down into ways that you can report as either an individual eligible professional, as a provider that's part of a group practice, as a provider that's part of an MSSP ACO, or as a provider that's part of a Pioneer ACO.

Reporting Once as an Individual Eligible Professional

So let's move on to slide 6, which starts the process for reporting once across these programs as an individual eligible professional. So one thing I want to clarify and call out for everyone on the call is that the 2015 reporting period satisfies the requirement to avoid the 2017 PQRS negative payment adjustment, the 2017 Value-based Payment Modifier, and the clinical quality measure component of the Meaningful Use Program for 2017. There is a delay between the reporting period and the period for when the penalty would be in effect. I just want to make that really clear to everyone on the call. So if there are other questions related to that, I'd be more than happy to take them at the end.

Moving on to slide 7. So, hopefully everyone can see this diagram well on the slide. If you can't, we do have this material covered in other documents that are posted on our website. So this provides a flow of how to report once for the 2015 program as an individual EP. The starting condition is that you are participating as an individual EP. An individual EP is typically either a solo practitioner or someone who is reporting in PQRS using your unique TIN, Tax Identification Number, or your unique NPI, your National Provider Identifier.

And there are — the two main ways that you can report once. And just to back up a little bit before I go through this flow, what we mean by reporting once is one of the goals we have here at CMS is to reduce provider burden wherever possible. It may not seem like that is a goal, but it is one of the ones we try to do, and it's something that we have been trying to do by implementing the alignment process across these various programs that currently impact providers. We know that providers are very busy, and they have a lot of patients that they need to see and other things they have to do during the day, so we have really tried hard to reduce burden and reduce any requirements that we have control over to ensure that alignment is possible.

So what I'm covering today isn't every single reporting option that is available under PQRS or the Meaningful Use Program or all of the details of the Value Modifier Program.

It's really focusing on, if you want to report once across all these programs, this is how you could do it.

So going back to slide 7, sorry for the brief departure. So the two main ways you can do that is by either reporting using an EHR or using a Qualified Clinical Data Registry, or QCDR. Using an EHR, there are two options — there are two suboptions. The first is submitting the EHR data directly from your certified EHR to CMS, and the other option is using a data submission vendor. A data submission vendor is essentially a third party that works on your behalf to submit data over here to CMS.

You would need to report on nine of the clinical quality measures that were finalized in our 2015 Physician Fee Schedule Rule for the full 12-month reporting period. There are specific versions of the measure that you would need to report on. We do have those called out in our rule, but we also have them called out on our website if you have questions related to that.

So you need to report the nine measures covering three National Quality Strategy domains. If you don't have a full nine measures covering three National Quality Strategy domains, you would need to report on as many measures, covering as many domains as you have available to you. You can report this data for all payers. So Medicare payers, non-Medicare payers, the Blues, United, Kaiser, etc., but just one of those patients must be Medicare Part B.

And then going down from there, there are two options. You either satisfactorily report under PQRS or you don't. So going to the left-hand side, at the Yes column, so if you do satisfactorily report, you would avoid the 2017 PQRS negative payment adjustment, which is a 2 percent reduction off your Physician Fee Schedule reimbursement. You would satisfy the CQM component of the Meaningful Use Program. Again, under Meaningful Use, there are core objectives and then the CQM component. This only — this reporting once only covers the CQM component. You would still need to attest to the remaining objectives within the Meaningful Use Program.

And then, depending upon how many providers are part of your TIN, your Tax Identification Number, there are different amounts of payments that you could receive under the Value-based Payment Modifier Program. So if you are a solo practitioner or if you are in a — if under your current practice that you work in has two to nine providers, you could receive an upward or neutral adjustment based on quality tiering between 0 to 2 percent — 2 percent of x. And x represents the Value Modifier adjustment factor if at least 50 percent of the eligible professionals under that TIN or solo practitioner satisfactorily report under PQRS.

And then the other group size is for — if you are in a practice with 10 or more providers. And from there, you could receive either an upward, neutral, or downward adjustment based on quality tiering, and that would either be a negative 4 percent or a positive

4x percent, again where x is the adjustment factor. Additionally, in 2017, groups and solo practitioners receiving an upward Value Modifier adjustment under quality tiering are eligible for any additional 1x if their risk score — their beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.

I know that is slightly complicated, so I'll go over it again throughout the presentation. And if you have questions on the different tiering structures, we'd be more than happy to take questions on that at the end.

So then going back to the middle, so if you do not satisfactorily report under PQRS, these are all the bad things that could happen to you. You could have a 2 percent negative PQRS payment adjustment. You would not satisfy the CQM component of Meaningful Use. And depending upon your practice size, you could either have a 2 percent reduction in your payment or a 4 percent reduction in your payment.

Reporting Once as Part of a Group Practice

OK. So let's move on now to the next slide, where we will be talking about reporting once as a part of a group practice. So next slide, again this is slide 9. So similar to individual eligible professionals, group practices can report quality measures one time during the 2015 program year to avoid the PQRS penalty, satisfy the CQM component of Meaningful Use, and satisfy the 2017 requirements for the Value Modifier.

And let's move on to slide 10. So this is another one of our diagrams, and this has the opening scenario where you are part of a group practice. And what we mean by a group practice here is that you are part of a TIN, a Tax Identification Number, with two or more NPIs, two or more National Provider Identifiers that have reassigned your rights to that TIN.

What you would need to do is you would need to register to PQRS under two different options. The registration process will be covered in an upcoming National Provider Call in April. The timeframe to register to be a PQRS group practice is from April 1st through June 30th. Again, we will be covering the registration process in more detail in our next call in April. But what you would need to do for these specific scenarios to apply to you is register as a group practice, and you would either select that you would be a group practice using EHR or a group practice using the web interface.

So let's first talk about the group practices who are using an EHR. So the most left-hand-side option is very similar to the one I just spoke about. So this is where you would report on nine clinical quality measures covering at least three of the National Quality Strategy domains. These would be the specific versions of the CQMs that were finalized in the Physician Fee Schedule rule last year, and you would need to report the nine measures covering three domains for as many patients as you have available both for Medicare and non-Medicare.

Then moving over to the right, the next option under the EHR heading is to report on six clinical quality measures covering two National Quality Strategy domains, and reporting on CAHPS for PQRS survey modules. The CAHPS for PQRS is required if you are part of a group practice that is 100 or more eligible professionals, and it's optional for group practices that are two to 99. It's something you can supplement your reporting on.

OK. So then let's move over to the right-hand side; so reporting via the GPRO Web Interface. There are two options using the GPRO Web Interface, and this only applies if you are a group practice with 25 or more eligible professionals. The first on the left side of the GPRO Web Interface bucket is if you are a group with 25 to 99 EPs, you would need to report on all of the measures contained within the web interface for the prepopulated sample. Additionally, you have the option to supplement your reporting by reporting on the CAHPS for PQRS survey module.

And then on the left-hand side, for groups that are 100 or more, you would need to report on all of the measures for all of the patients within the GPRO Web Interface. And since you are that group size of 100 or more, you would — you are required to do the CAHPS for PQRS survey module.

So then moving down, so then our two options, again, are either to satisfactorily report under PQRS for 2015, yes or no. You'll notice that the yes or no scenarios are very similar across the board. So for the yes scenario, you would avoid the PQRS negative payment adjustment. You would satisfy the CQM component of Meaningful Use, noting again that you would still need to attest to the remaining Meaningful Use objectives that are required under that program. This only would account for the clinical quality measures.

And then depending upon your group size, there could be various options that would happen to you under the Value Modifier program. If you are part of a smaller group, a group of two to nine, you could either have a neutral VM or a 2x VM, again, where x is the adjustment factor. If you are in a group size of 10 or more providers, you could either have a downward, neutral, or positive VM, ranging from negative 4 percent to a positive 4x. Again, additionally, there is the additional 1x that you could earn if you have a high-risk beneficiary risk score.

And then moving over to the no side, so if you do not satisfactorily report under PQRS, all the negative things that could happen: You could receive the PQRS negative payment adjustment; you would not satisfy the CQM component of Meaningful Use; and you would receive an automatic downward adjustment under the Value Modifier. Again, depending upon your group size, it would either be a 2 percent reduction in claims or a 4 percent reduction claims.

Reporting Once as Part of a Medicare Shared Savings Program ACO

So let's move on to the next slide. Now I will be talking about how you can report once as part of a Medicare Shared Savings Program ACO.

Slide 12. So similar to what I've covered previously, Medicare Shared Savings Program ACOs, they can report once to avoid the PQRS penalty, satisfy the CQM component of Meaningful Use, and satisfy the requirements for the 2017 Value Modifier.

So let's move on to slide 13. So we have another diagram. And the scenario here is where you are a Medicare Shared Savings Program ACO. You have signed up to be an SSP ACO and you have assigned your billing rights to the Shared Savings Program ACO participant TIN.

What you would need to do is that the ACO primary TIN would need to report on all of the measures included within the GPRO Web Interface. And then there are two options. You could either satisfactorily complete the GPRO Web Interface or you would not. If you do, then the primary TIN would avoid the PQRS penalty, you would satisfy the CQM component of Meaningful Use. Again, the same caveat is in place that all of the NPIs under the TIN would need to individually attest to the Meaningful Use Program.

And then for the Value Modifier, there is a different amount of payment at risk for Medicare Shared Savings Program ACOs. So if you are part of a group of two to nine EPs or a solo practitioner, you could get an upward or neutral VM up to 1x. If you're in a group of 10 or more, it would be either a negative 2 percent reduction to neutral or 2x. And there would still be additional 1x that you could receive for the high-risk beneficiary population that you could serve.

And then on the no side, if you do not satisfactorily report, you would receive the 2 percent negative PQRS payment adjustment, you would not satisfy the CQM component of Meaningful Use, and on the Value Modifier, you would automatically get either a 2- or a 4 — either a negative 2 percent or a negative 4 percent Value Modifier reduction, depending upon your group size.

Reporting Once as Part of a Pioneer ACO

Next slide, so slides 14 and 15, so talking about the Pioneer ACOs. So this is where you are part of a Pioneer ACO. And, again, you could avoid the PQRS negative penalty, satisfy the CQM component of Meaningful Use, and satisfy the requirements for the 2017 VM.

So go ahead and move on to slide 16. So this is where you — your organization — has signed up to be a part of a Pioneer ACO. And you have assigned your billing rights to the Pioneer ACO participant TIN. So similar to the Medicare Shared Savings Program ACO,

the Pioneer ACO primary TIN would report on all measures available within the GPRO Web Interface. And if you do so satisfactorily on the yes side, you would avoid the PQRS negative payment adjustment, and you would satisfy the CQM component of Meaningful Use, and you would receive a neutral Value Modifier in 2017. On the no side, if you don't satisfactorily complete, you would receive the PQRS penalty, you would not satisfy the CQM component of Meaningful Use, and you would still receive a neutral Value Modifier in 2017.

Resources

And that covers everything that we have today. The remaining slides cover our resources. This is something important that we feel that everyone should take a look at. So slide 18 covers our website and a lot of our fact sheets related to the program. The very first link on slide 18 is the document from which this presentation was pulled from. Slide 19 contains our information for all of our various help desks. Slide 20 covers our acronyms.

And at this point, I will turn the call back over to Aryeh. Thank you.

Keypad Polling

Aryeh Langer: Thank you Molly. At this time we will pause a few moments to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results.

Victoria, 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 1. If there are between two and eight of you listening in, enter the corresponding number. If they are nine or more of you in the room, enter 9.

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

Thank you. I would now like to turn the call back over to Mr. Langer.

Question-and-Answer Session

Aryeh Langer: Thank you. Our subject matter experts will now take your question about today's call. But before we begin, I would like to remind everyone that this call is being

recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue and we will address additional questions as time permits.

Victoria, we are now 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 you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Candace Kaiser.

Candace Kaiser: Can you tell me how many patients per group or provider if we're doing the PQRS through the group?

Molly MacHarris: Hi, this is Molly from the PQRS team.

Candace Kaiser: Hi.

Molly MacHarris: So do you mean for the GPRO Web Interface reporting option, or are you looking for another option?

Candace Kaiser: We're looking at the PQRS and we're looking at the group measures.

Molly MacHarris: OK. Are you looking at the web interface option under that or the EHR option?

Candace Kaiser: We're hoping it's EHR, but is there a difference for each?

Molly MacHarris: Well, so, on the EHR option, you would need to report on all of the applicable patients for the measures.

Candace Kaiser: How many is that?

Molly MacHarris: And that is covered in the presentation today on slide 10. That was the "how to report once as part of a group practice," and that was on the left-hand slide — side of the slide.

Candace Kaiser: Right.

Molly MacHarris: If you're participating via the GPRO Web Interface, the reason that we're asking is that that has a preassigned and sampled beneficiary population for you that's based on a sample of 248 patients per measure that you would have to fill out. Does that help answer your question?

Candace Kaiser: No. What I was trying to ask is for — let's say, we're doing it through a registry and we're doing the PQRS …

Molly MacHarris: Um-hum.

Candace Kaiser: … and we're doing the nine measures and the three demands — domains …

Sophia Autrey: Domains. Yes, you can't do measures group.

Candace Kaiser: Pardon me?

Sophia Autrey: So your question — hello, this is Sophia Autrey with CMS. So your question about — is about the measures group and how many patients you would need to report on for the measures group?

Candace Kaiser: Yes.

Sophia Autrey: OK, so there's a sampling of 20 patients for the measures group.

Candace Kaiser: Oh, so it's 20 like it was this year.

Sophia Autrey: Yes.

Candace Kaiser: OK.

Molly MacHarris: And the one thing that we just want to call out for that is you cannot report on that option as a group practice. You would need to report it as an individual eligible professional.

Candace Kaiser: When you do the 20, it's individual?

Molly MacHarris: If you're reporting via registry using the measure group. So each unique TIN NPI would need to report on 20 patients for a specific measure group. That option is not available as part of a group practice.

Candace Kaiser: Right. So it's 20 per provider?

Molly MacHarris: Correct.

Candace Kaiser: OK. And where are those lists of measures? Are they on any of your web pages?

Molly MacHarris: Yes. They are available on our website. If you look at slide 18, it's the PQRS website.

Candace Kaiser: OK. Which is — which one? Oh, CMS PQRS website?

Molly MacHarris: Correct. Yes.

Candace Kaiser: OK.

Molly MacHarris: And if you click on the Measures tab, that can take you to the measures.

Candace Kaiser: Perfect. That's great.

Molly MacHarris: Thank you.

Candace Kaiser: And even though all of our providers, there's two physicians and one nurse practitioner, they all count in the group, right?

Molly MacHarris: They are each considered a PQRS eligible professional.

Candace Kaiser: Perfect. Thank you.

Molly MacHarris: Thank you.

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

Jennifer Wenning: Hello, my name is Jennifer. I'm calling from Medical Imaging Physicians. We are a radiology group of 15 doctors. We're currently reporting via claims, and we're considering if we should be changing to registry or if we should be changing to a GPRO. I'm wondering if claims reporting is going away and so the registry reporting would be recommended or — and am I understanding your slide correctly that GPROs do not have the option of reporting via registry if we change from individual to GPRO?

Molly MacHarris: Hi, this is Molly MacHarris again. So you can report via a registry as part of a group practice. We didn't cover it in the slides today because you cannot report via registry and "report once," which was the focus of the presentation today. So if you are looking to participate in the Meaningful Use Program, you would need to report your CQM separately using the registry option. But the registry option is available if your providers choose to report as either individuals or as part of a group practice. We

do have a fair number of radiology measures that are available for registry-based reporting, and those are available on our website.

Jennifer Wenning: Is claims reporting going away?

Molly MacHarris: Claims reporting is still an option, as we've indicated in the past 2 years Physician Fee Schedule Rule. The agency as a whole is moving more towards electronic-based methods of reporting. So it is a shift that we are starting to make, but currently the claims-based reporting option is still available. If and when the claims-based reporting option goes away, we would make that very clear in the final — in the proposed and final rule.

Jennifer Wenning: Thank you.

Molly MacHarris: Thank you.

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

Dr. Tac: Hi, I'm a sole practitioner. I have about 40 clients, and I only have two clients who are Medicare. And I just want to have the measures in my hand, give it to the clients, and fax them back to you. Is that impossible? And I'm also a researcher, so. But it's just been so difficult because I only have two clients who are Medicare and I'm deciding to take the 2 percent penalty, and like see these people practically for free with all the problems that this is causing when I only have two, you know, two clients who are Medicare eligible. So I just want to give them the measures and fax them back to you and you have them, or that's totally impossible?

Sophia Autrey: Hi, this is Sophia Autrey. Can I ask, what's your specialty?

Dr. Tac: My specialty is EMDR couples therapy, individual. You know, I'm an individual practitioner. I have a Ph …

Sophia Autrey: OK.

Dr. Tac: … you know, and I see clients. I don't mind giving them the measures because I'm a researcher. I just want to give the clients the measures and fax them back to you.

Sophia Autrey: OK.

Dr. Tac: Or I don't want my — I don't have such a big practice. I only have two clients who are Medicare. So I chose to take the 2 percent penalty and practically see them for free.

Sophia Autrey: OK, so we do — we do not have a lot of behavioral health measures in the program, but we do have a few. And some of the cross-cutting measures, you can report on just based on what you do as a practice, but …

Dr. Tac: Right, and …

Sophia Autrey: … those measures don't — they're not like patient engagement or patient reported outcomes in which the patient would complete the information. They're information based on you as a clinician and how you address that clinical action. So …

Dr. Tac: I've already given the mini 500. I do a thorough diagnosis in terms …

Sophia Autrey: OK.

Dr. Tac: … of my clients using research measures.

Sophia Autrey: Right. So based on what you do as a clinician, then you look at applicable measures for you, and then you report on those measures. Those don't go to the patient to complete and are sent to us. But we do have a way that — we do have information further of how you can report those measures, and you can get additional information for that from the …

Dr. Tac: Well, can you give me a person to call so …

Sophia Autrey: Yes.

Dr. Tac: … I'm not getting — because I spend a lot of time with my Medicare clients because they usually have Medicare and something else. So I just want a person that I can call. And I want to do this. And because I'm a researcher, I want to do it. But you've made it so difficult for me, and I've tried to get help and I can't get help. So I just want a person that I can talk to — like I have a client tomorrow at 10 o'clock who's a Medicare client who's suicidal. I know she's suicidal. I've given her the suicidal measures, but I haven't given them to you. I'd like to, but I said, "Oh my goodness. I have to go through all of this for one client?" So can I have some person that I can speak to and go over my case individually so I can be compliant and not say, "OK, I'm not going to …" because the next step is, I'm not going to take Medicare clients?

Molly MacHarris: Ma'am, ma'am, so if you look at slide 19, if you …

Dr. Tac: I'm – yes, I'm on 19, go ahead.

Molly MacHarris: For the QualityNet Help Desk, if you call them, they can walk through with you exactly what you need to do to participate in the program and where to send

the information into. So if you contact the QualityNet Help Desk, they can help you with all of that.

Dr. Tac: And I'm going to be on the phone for half hour or 45 minutes before they pick up the phone …

Molly MacHarris: If you — if you prefer to email them, you can email them as well.

Dr. Tac: I see it, right. But do you see that I only have two clients out of my 35 clients who are Medicare?

Molly MacHarris: We understand your concern, you know. We understand that there are lots of providers out there who see a small Medicare population. We are required by law to implement these programs that apply for all Medicare providers. So we understand your concerns that, you know, there may not be sufficient quality measures for your particular specialty. So that's something that we are aware of and we are working actively with the various specialties that are out there. So the best option that we can give to you at this point in time is to contact the help desk, and they can go through with you step-by-step of what you would need to do and for your particular practice what measures would be most applicable.

Dr. Tac: OK. And also, all right, I have this one machine …

Aryeh Langer: Ma'am, I'm sorry. We have lots of callers …

Dr. Tac: OK, that's fine.

Aryeh Langer: … in the queue and we appreciate your question. If we could go on to the next caller, please.

Dr. Tac: That's …

Operator: Your next question comes from the line of Frances Deglandon.

Frances Deglandon: Yes, hi, this is Frances Deglandon, CFO at Bunkie General Hospital. We're a small critical access hospital in Louisiana, and our problem is for the reporting period, we only had one employed physician. So our data is very limited. The physician works out of a rural health clinic, which we do not bill Part B. So it's only his inpatient stays that we have information on, and we did not have enough information to submit to be included in the incentive. We had enough information to avoid a penalty, and that was after multiple days of pulling. We went through every measure until we could find measures where we had enough information. So I guess my question is, is that this is new to us, we did not file to avoid the penalty for this year because we were unaware that it was mandatory. Is there something that is geared towards critical access

hospitals that we can go and read, education to try to help us out in these situations where there's just not enough data to report?

Molly MacHarris: Hi, this is Molly. So we do have information available on our website. If you look at slide 18, the PQRS website, we do have information related to the critical — if you go there and if you look on our website, we do have information that is specific to critical access hospitals billing method, too. So I would suggest you take a look there.

If you have additional questions, if you look at slide 19, the very first help desk, the QualityNet Help Desk, they can walk through with you what you are required to do to participate. The one thing I did just want to call out from when you were explaining your specific situation that you don't have a lot of Medicare Part B data, the way that our programs are structured, it doesn't — we don't have a low-volume threshold for precluding people from participation. So if you have one patient, two patients, 20 patients, 500 patients, and if you're billing under Medicare Part B, that means that you are eligible and able to participate in our program. So I did just want to call that out for you and the other callers on the line here that there really isn't any difference …

Frances Deglandon: And I understand that part, and I guess, you know, if we can't even qualify for the incentive because of the low data, you know. We were lucky to avoid the penalty. I mean we reported 100 percent. But we had three patients that met the criteria. So that, you know, I reported all three, and that's great and wonderful, I'm fine with that not, you know, just not having the penalty. But …

Molly MacHarris: Right, right. We understand. And so, I did just want to give you the article that I think would be most applicable for you if you go to our website and if you search, it's MLN …

Frances Deglandon: Yes.

Molly MacHarris: … article S as in Sam, E as in Edward 1508. So if you look at that, that should answer the rest of your questions related to billing as a critical access hospital.

Frances Deglandon: Just one more part of my question is, do you have a recommendation for us to report? We actually — because we were delayed, we actually went through a registry to report this information. For critical access hospitals with low volume, do you — would you recommend a reporting mechanism that would be probably the easiest, whether it be through our claims data or …

Molly MacHarris: You know, sorry to cut you off. You know, it does really depend on your specific practice. A lot of providers find that the claims option, they do prefer. It's something that you would have to append the quality data code on for every eligible patient that you see. The registry option is very popular as well. So it really would depend upon your specific practice. One of the things we do encourage people to do is

take a look at the measures you would want to report on and then look to see which reporting options those measures are available via because not every single reporting option has the same number of measures. I will say, though, that the registry option does have the largest number of measures available. So I hope that answers your questions, and I believe we do have to move on to the next caller …

Frances Deglandon: OK, thank you very much.

Operator: Your next question comes from the line of Cheryl Minardi.

Cheryl Minardi: Cheryl Minardi with Dermatology Associates of Colorado. My question is, if an individual eligible professional who reports through a registry wants to report once, can the measures be selected from a combination of the CQM list and the PQR list? And do they have to report on all patients or just Medicare patients?

Lauren Fuentes: Hi, this is Lauren Fuentes with CMS. Let's see your question, the first part of it, you're interested in reporting once for both PQRS and the EHR Incentive Program or Meaningful Use, is that correct?

Cheryl Minardi: Correct.

Lauren Fuentes: So you can't actually report once using the registry method. The registry method would be applicable for PQRS reporting only. So for Meaningful Use, you do need to use certified EHR technology to report your measures. But you can report the same measures, the same eCQMs for PQRS and then also receive credit on the EHR Incentive Program for those measures.

Cheryl Minardi: OK, thank you.

Lauren Fuentes: Sure.

Operator: Your next question comes from the line of Stefan Black.

Stefan Black: Yes, hello. My name is Stefan Black, and I am the owner of a solo practitioner chiropractic office in Seattle, Washington. We've not reported before, have not had current EHR but will be transitioning before October. So, in the interim, how do I use or find the qualified clinical data registry option to submit or to be in compliance?

Molly MacHarris: Sure, this is Molly MacHarris again with CMS. So information related to the QCDR option is available on our website. Again, that information is on slide 18. If you click on our website on the left-hand side, there is a link to the qualified clinical data registry. We haven't yet posted the list of qualified clinical data registries for 2015. We do anticipate posting that within the next few months. So what we would recommend that you do is once that document is available, take a look at it and see if there's a QCDR

that would more pertain to your specialty or if they have measures that you want to report on, and then you would contact them.

When you contact them you would, you know, enter an appropriate business agreement between you and the QCDR where you would select the measures that you would be reporting on and they would work with you to make sure that you provide them the data that they need to then provide to us here at CMS.

Stefan Black: I'm on page 18 right now, so I apologize. Where …

Molly MacHarris: It's the third one down, the CMS PQRS website. If you click on that and then on the left-hand side of our website, there's an option called qualified clinical data registry. That's about halfway down.

Stefan Black: All right.

Molly MacHarris: And if you have other questions, you can always contact our help desk, it's the QualityNet Help Desk. Thank you.

Stefan Black: Quality something help desk. What was that?

Molly MacHarris: The QualityNet Help Desk on slide 19.

Stefan Black: Thank you very much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Pat Harder. Pat Harder, your line is open. Please proceed with your question.

Pat Harder: Yes, can you hear me?

Molly MacHarris: Yes, we can hear you.

Pat Harder: OK, my question is if on the, basically, the penalties, is that only on the Medicare Part B payments or Part A also?

Molly MacHarris: Sure, this is Molly again. The programs that we're talking about today are specific to Part B.

Pat Harder: Um-hum.

Molly MacHarris: I can't speak to whether or not there are other penalties that could be applied on the Part A side. So I can answer you that what we're talking about today is specific to Part B.

Pat Harder: OK, so if we didn't meet PQRS for the — for this like right now we'd be — we'd be hit with the Part B payments for sure, but you don't know about Part A.

Molly MacHarris: Correct. Part A would be handled by a different component. And unfortunately, we don't have the subject matter experts here in the room on whether or not there are similar programs on the Part A side.

Pat Harder: OK, all right.

Molly MacHarris: Thank you. Have a good day.

Pat Harder: Um-hum, all right.

Operator: Your next question comes from the line of Jorge Grillo.

Jorge Grillo: Jorge Grillo of Canton-Potsdam Hospital. I think it was answered in the last question, which was basically, does the penalty apply to Medicare Part B only?

Molly MacHarris: And this is Molly again, and yes, that is correct. The programs that we're talking about today are specific to reimbursements you would receive under Medicare Part B.

Jorge Grillo: Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Kevin Dearing.

Kevin Dearing: Hi, this is Kevin Dearing with Sutter Health. My question is around the — well, currently, we report through the GPRO. And we have several — we have over, you know, hundreds of providers. So when we report our GPRO measures once, how do we know which physicians we would still need to report the Meaningful Use clinical quality measures for?

Molly MacHarris: This is Molly. So let me just make sure I'm fully understanding your question. So you are participating as a group practice and you want to know for Meaningful Use what providers you would still need to — are you talk — you would still need to attest for, for the CQMs or for the remaining core objectives?

Kevin Dearing: For the remaining CQMs.

Molly MacHarris: So you would need to do that for every NPI that is at your practice. So every provider that you have, they would still need to meet Meaningful Use or else that specific NPI could receive the Meaningful Use penalty.

Kevin Dearing: So the reporting once for the GPRO, if I'm understanding right, does not satisfy the Meaningful Use clinical quality measure reporting component?

Molly MacHarris: It does satisfy the clinical quality measure component, it does not satisfy the remaining objectives of Meaningful Use.

Kevin Dearing: Um-hum.

Molly MacHarris: So as you know, under the Meaningful Use Program, there are around 15-some odd objectives and then the CQM component, the clinical quality measurement component. Reporting once, so what we've talked about here today, only covers the clinical quality measure piece. So each provider that is at your practice would still need to individually attest to the other objectives.

Kevin Dearing: So— yes, so my question is, how do I know which providers are picked up in the PQRS GPRO reporting?

Molly MacHarris: It would be every provider —every NPI that is associated with your TIN during the reporting period. So for the 2015 year, it would be every single NPI that bills under your TIN during calendar year 2015. And every single one of those NPIs would need to separately attest to the core objectives under Meaningful Use.

Kevin Dearing: So what about the quality measures?

Molly MacHarris: The quality measure piece would be covered if you sign up as a group practice for either the EHR reporting option or the web interface. When you submit the data over here at CMS, we would look under your Tax Identification Number to determine who were all of the NPIs that billed for the reporting period. So we would look to see if you had, for example, 405 NPIs that billed under your TIN. In 2015, if you did in fact have all of those, we would share those with the Meaningful Use Program. If you …

Molly MacHarris: I know this can get complicated, so if you have other questions, I would suggest contacting the QualityNet Help Desk, and they can walk you through this in more detail than I can here on the call today.

Kevin Dearing: OK.

Molly MacHarris: OK, thank you.

Operator: Your next question comes from the line of Debbie Mackin.

Debbie Mackin: Hello?

Molly MacHarris: Hello, we're here.

Operator: Hello Debbie, please proceed with your question.

Debbie Mackin: Yes, I'm calling from Dr. Scott McKenna's office. We are currently a solo practitioner, and doctor is in the process of hiring a physician's assistant. Now I will be billing with her, rendering NPI, but it's still under the solo or the group doctor's corporate Tax ID Number and NPI. Does that consider us a group now? Or are we still — can we still report as an individual?

Molly MacHarris: This is Molly again. So you're only considered a group practice if you register to be a group practice. So just by simply adding another physician to your practice under our PQRS or Value Modifier terminology does not make you a group practice. So what you would …

Debbie Mackin: OK.

Molly MacHarris: … need to do is when that additional provider joins your practice, make sure they also have an NPI. And …

Debbie Mackin: Um-hum.

Molly MacHarris: … you could — you would have the option to sign up as a group. Or you could have the two providers reporting to meet the PQRS and the other requirements separately as individual …

Debbie Mackin: OK.

Molly MacHarris: … eligible professionals.

Debbie Mackin: OK. Even though she's just —not just, but a physician's assistant because we are billing with the rendering NPI, she has to meet the — they have to meet the requirements also. Correct?

Molly MacHarris: Yes, correct. A physician assistant under PQRS is considered an eligible professional.

Debbie Mackin: OK, so right now it's an option, it's not necessary to report as a group?
Molly MacHarris: Well, since I understand you only have one provider right now, then …

Debbie Mackin: Yes.

Molly MacHarris: … no, you couldn't report as a group. But when the other provider comes you could register to be a group practice as a group of two if that's something you're interested in.

Debbie Mackin: OK.

Molly MacHarris: But it's not required.

Molly MacHarris: Thank you.

Debbie Mackin: All right, great. All right, thank you.

Operator: Your next question comes from the line of Denise Nero.

Denise Nero: Ah, yes, I have a question. We are currently not using an EHR system. We do claims based for PQRS but was wondering, do you still need to register?

Sophia Autrey: Hi, this is Sophia Autrey. And no, you don't have to register to submit claims. I think measure as individual EP.

Denise Nero: OK, as a group?

Sophia Autrey: If you're registered — if you are reporting as a group?

Denise Nero: Yes.

Molly MacHarris: This is Molly …

Denise Nero: Yes, by submitting claims in …

Molly MacHarris: If you're reporting as a group practice, reporting as a — reporting via claims is not an option available to you. So if you want to continue to report via claims, your practice can only do it as individual eligible professionals. So each unique TIN NPI would have to meet the reporting criteria.

Denise Nero: Oh, OK. So you'd have — OK.

Denise Nero: OK, so you'd have to have separate TIN numbers for reporting?

Molly MacHarris: You'd have to — so each TIN NPI that is under your practice …

Denise Nero: Yes.

Molly MacHarris: … would have to meet the criteria. So one doctor would have to do nine measures, covering three domains, another doctor would have to do the same.

Denise Nero: OK. And then you mentioned about the need to register for the PQRS is April 1st to June 30th?

Molly MacHarris: Since you're reporting via claims …

Denise Nero: Um-hum

Molly MacHarris : … you don't need to register. So …

Denise Nero: Right.

Molly MacHarris: … only would need to register if you want to be a part of a group practice.

Denise Nero: Um-hum.

Molly MacHarris: Claims reporting is not available for group practices, so, therefore, you don't need to register.

Denise Nero: OK. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Gregory Kotlarz.

Gregory Kotlarz: Hi, this is Dr. Kotlarz from Seniors Wellness Group, geropsychiatric practice in Michigan. And first — well, my question is, are the 2015 measures tied in with specific CPT service codes for use?

Hello?

Sophia Autrey: Hi, this is Sophia Autrey and, yes, there are measures that are tied with service codes, CPT service codes.

Gregory Kotlarz: OK. Well, you know, our problem — we're a fairly large practice. We have about 70 clinical staff physicians, psychiatrists, nurse practitioners, physician assistants, psychologists, and social workers. We have not been able to report for our

prescribing staff who use exclusively evaluation and management codes because none of the measures tie in with those — none of those measures for psychiatric providers tie in with the evaluation and management codes that we use in our practice in extended care settings. So we're being penalized, you know, for past years already and I was hoping that, you know, CMS address this problem for practices such as ours.

Now, we're going to — evidently, we're subject to as high as a 4 percent penalty for 2015, you know, coming into effect in 2017. What do we do?

Molly MacHarris: Hi, this is Molly. So you did mention the E/M codes. I did just want to call out that the E/M codes are available in the majority of our measures. So that is something that I would take a look into if I were you. One of the best …

Gregory Kotlarz: Well, excuse me, Molly, I, as well as other of my administrative staff, we personally reviewed every measure for 2014 to see what codes would be viable for us, and we did not have those codes. The codes that are — there were insufficient codes to use. Sure, there are codes that pertain to other medical specialties that tie in with the E/M codes that we use. And again, our E/M codes are specific to our practice setting, which are in skilled nursing facilities, assisted living facilities — in those two settings. And so the codes that we use do not tie in with measures that are viable for us. There are ones for cardiology, neurology, other medical specialties, but when you look at geropsychiatry in the long-term care setting, that will not be found.

Molly MacHarris: OK.

Gregory Kotlarz: So we have, you know, we determined we had no option there but to …

Molly MacHarris: OK, that's helpful. Thank you for clarifying more your practice. We didn't understand that initially.

Sophia Autrey: Right, OK. Thanks for that additional clarification. So because of that, we are going to send you to the help desk because I think that you need a little bit more specificity in your answer than we can provide on this call. But generally, what they can do is look at each one of those measures and walk you through which ones, based on the E/M codes you used and based on the CPT code, which would be applicable for you, and they could do specific for you. So if you look on slide 19, you'll find the contact information for the QualityNet Help Desk, and they can walk you through that or your administrative staff.

Gregory Kotlarz: OK, thank you.

Sophia Autrey: Thank you.

Gregory Kotlarz: Just one very brief question. Are there separate thresholds for prevention of the penalties and eligibility for the incentives?

Molly MacHarris: There aren't. There — so if you report any Medicare Part B claims that have a measure associated with them, then you are eligible and able to earn the PQRS incentive — 2014 was the last year for that — and/or receive the payment adjustment.

Gregory Kotlarz: OK. So for 2015, the threshold is nine measures that are required to both prevent penalties and then to receive the incentive bonus?

Molly MacHarris: Correct. There is no more incentive in 2015, so it's only nine — the — sorry, the threshold is nine measures covering three domains to avoid the penalty in 2015 …

Gregory Kotlarz: OK.

Molly MacHarris: … for the 2017 year.

Gregory Kotlarz: OK, thank you.

Molly MacHarris: Thank you.

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

Linda Stevens: Hi, hello? Hi, this is Linda Stevens. Can you hear me?

Aryeh Langer: Go ahead.

Operator: Linda, please proceed with your question.

Aryeh Langer: Go ahead Linda.

Linda Stevens: Yes, OK. My question is — my name is Linda Stevens. I work for Advanced Foot and Ankle Center, and I have a couple questions. Right now we do PQRS reporting by claims. We have not been able to do nine measures. So for the first part of this year, we didn't report all nine, we've been reporting like four, because we didn't know it had changed.

So my two questions are — is there any way to avoid the penalty if you can't report nine, you know, if you only report as many as you can? And the second thing is, if you report this one-time reporting with the PQRS and the CQM, and then you do the Meaningful Use through the EHR, does that — is that going to pull over? Is that going to, you know, come together in the end, I guess?

Sophia Autrey: So hello, this Sophia Autrey, and to address your first question. If you do not report nine measures or cannot report nine measures covering the three domains, then what we consider measure applicability validation process is actually triggered. So what that means is, based on the measures that you did report, it goes through that math process to see if there were additional measures that could be reported. And if there were not, once you go through that math process, then you could pass math and satisfactorily report. So you would not need to have that nine measures covering three domains if there aren't additional measures that you can report.

And can you repeat your second question, please?

Linda Stevens: Oh, yes. I just — I just wanted to respond to the first part. How do you know what measures? You know — we're a podiatrist office, and so, you know, our practice is limited to feet. So how do you know — there's no way of knowing if additional measures would be applicable to us.

Sophia Autrey: OK, so based on the CPT codes that you utilize when reporting the measures that you do report, and there are identified clinical clusters to the math process. It actually goes through that applicability to see if there are additional measures that could've been reported. And we have now computer-based training and actual supplemental guides for the math process on the PQRS website — PQRS website that you can access to thoroughly learn about that process.

Linda Stevens: OK, thank you about that. And then the second part is, if — well, actually it's a little different. If you report — if you've been reporting claims, and then you decide to do this one-time reporting, can you switch in the middle, or how does that work?

Sophia Autrey: So when you say switch in the middle, you mean in the middle of the reporting period?

Linda Stevens: Right, right.

Sophia Autrey: You want to report on multiple reporting options?

Linda Stevens: Right, because now this year's already — you know, we're into March already, so we've been reporting by claims already. If we're already doing that, can we switch to registry? Or can we do this one time option?

Lauren Fuentes: So, hi, this is, Lauren Fuentes. So, I mean, there's no penalty for, you know, the, you know, they'll be no negative for using multiple reporting methods, but you can't — we're not going to combine your data across reporting methods. So I think it's in your best interest to choose one for the reporting year and stick with that.

Linda Stevens: OK, OK, that makes sense. And then my last question was, because we report Meaningful Use in the CQM through our EHR and the PQRS through the claims reporting to the EHR, if you would do this one-time reporting, would — then when you do your Meaningful Use attesting, does it come together?

Lauren Fuentes: So only the clinical quality measure — this is Lauren again. Only the clinical quality measure piece is together, so you submit your nine measures across three domains using certified EHR technology and that will give you your PQRS quality measure reporting and will also count towards your EHR incentive program, but only the eCQM portions. So you still do need to attest separately for the EHR system for the other, you know, functional measures.

Linda Stevens: Oh, OK, that helps me clear that up. I appreciate your help. Thank you.

Lauren Fuentes: Great, thank you.

Aryeh Langer: Thanks. So, if we can remind the callers to try to keep to one question. There are many people who would like to ask questions of our subject matter experts.

Operator: And your next question comes from the line of Sallee Lowery.

Sallee Lowery: Hello, yes. This is Sallee Lowery and I'm calling for a single provider who is a clinical psychologist. We were under the impression that those — as a — is not an eligible provider for the ER — EHR or Meaningful Use, is this true?

Tim Jackson: This is Tim. So, yes, behavior health is in the EHR Incentive Program.

Sallee Lowery: It is?

Sophia Autrey: Yes.

Sallee Lowery: Does that mean he has to report for Meaningful Use?

Tim: Yes.

Sallee Lowery: OK. Is that — and that — when did that begin? Sorry to ask multiple questions.

Tim Jackson: So that has been in — since the program was started. So there's three stages to Meaningful Use, and we are in Meaningful Use Stage 2, but it is dependent on the beginning of the practitioner's entry into those stages and …

Sallee Lowery: Um-hum

Tim Jackson: … and the best that I can give you — I don't have the information on the EHR help desk.

Molly MacHarris: It's on — it should be also on slide 19.

Tim Jackson: Can you go to slide 19 in the packet?

Sallee Lowery: Um-hum. It is, yes, it is there, yes.

Tim Jackson: OK. That's where you want to start to get your information …

Sallee Lowery: OK.

Tim Jackson: … in proper order. Thank you.

Sallee Lowery: OK, thank you.

Operator: Your next question comes from the line of Barbara Baker.

Barbara Baker: Hi, I have some questions. I'm calling from a physical therapy group in Colorado Springs, and looking at APTA website because we are new to this, we had not been reporting because we were unaware of this program until I received a letter in December of last year. So we're trying to get onboard for this year and had not submitted any claims at all for Medicare. They're showing six major numbers to report on for physical therapy, three of which are to be reported each visit because we're considering doing claims reporting as opposed to registry right now. But the CPT codes are like for initial eval and then re-eval, and then the third CPT code is one that we don't even use. So I'm a little confused as how to do this because I want to do it right so that we don't get penalized any longer as of 2017, but I'm not quite sure how to do this.

What would be the best way to — what can I do? Because I've called the help line two or three times, but they just refer me to different articles to read. I've not found them to be extremely helpful in trying to help me figure out exactly how I need to do this on a step-by-step basis.

Sophia Autrey: Hi, this is Sophia. So, unfortunately, I don't have the list of measures in front of me that would identify the best measures for you. But I do want you to do two things: Number one, you can go to the help desk and they can directly work with you to identify which measures would be appropriate based on your practice and also the reporting options that you want to use. And number two, I think, we do have an

upcoming presentation that you would benefit from. And let me get the information for that, for a moment. So I'm going to hold for 1 second.

Barbara Baker: Sure, thank you very much.

Sophia Autrey: So — and you may already know this. This is Sophia again, but there is a presentation scheduled for tomorrow that includes APTA.

Barbara Baker: Oh.

Sophia Autrey: So if you may have registered for that already …

Barbara Baker: No, I did not.

Sophia Autrey: Oh, sorry.

Molly MacHarris: It's actually on Friday.

Sophia Autrey: It's actually on the 20th. Sorry about that.

Barbara Baker: Oh. And I don't know that because I work over at the clinic on Friday afternoon, so I don't know that I can attend that.

Sophia Autrey: OK, but you can call the QualityNet Help Desk to …

Barbara Baker: OK.

Sophia Autrey: … get the specific information that is available for your practice and the reporting option that you want to use.

Barbara Baker: OK. And can I ask just one other quick question? There are two full-time PTs in the clinic and one who works 2 days a week. How many patients — Medicare patients — do they need to report on per — there's one TIN number. Each of them has their own NPI numbers, of course. But how many would they need to report on of the Medicare patients, all of them or a percentage of them?

Sophia Autrey: So it would depend on how you're reporting. If you're reporting the individual measures and they are reporting as an individual eligible professional, they need to report on 50 percent of their patients. If you're reporting via the measures group, you need to report on a minimum of 20 patients, and it would depend on whether you want to register as a group practice. So all of that information depends on how you choose to report.

Barbara Baker: OK, great. And this is something that the help desk could ask if I had further questions?

Sophia Autrey: Yes, definitely.

Barbara Baker: Or could answer if I have further questions.

Sophia Autrey: Definitely.

Barbara Baker: Great. OK, thank you very much. I appreciate your help. Bye.

Operator: Your next question comes from the line of Gary Minnier.

Gary Minnier: Yes, hello. We are a behavior health provider. My name is Gary Minnier, and I'm calling from TrueNorth Wellness Services. And we have two psychiatrists that qualify for Meaningful Use. But like one of the previous callers, we have some clinical psychologists and clinical social workers, and they do not meet their requirements for Meaningful Use. So, in total, we have about 22 providers who would meet the requirements for the PQRS, but only two, which are our psychiatrists, would meet it for CQMs.

So, regarding the PQRS, we're trying to figure out, we know which measures that we are going to be capturing. And we know how to capture that data. But we're trying to figure out — because one reporting is for only two of our providers and one is for 22 of our providers, it doesn't seems like we can report them the same way. We know how to do the attestation for Meaningful Use. But it just doesn't seem like the — you know, in some of the slides you talk about how, you know, you have to do the PQRS to qualify for the CQMs. But we're seeing that we almost — it doesn't seem clear that not all of our providers stick for the both of the — both of the programs. Does that make sense, what I'm trying — like I'm trying to figure out how to, you know, how to report properly for each of the separate programs because …

Molly MacHarris: Sure, sure. So this Molly again. And we did want to clarify a response we gave earlier related to behavioral health providers and Meaningful Use. So Tim, did you want to clarify that?

Tim: Right. So, as you identified, it's the physician in the behavioral health clinical practice that is the eligible practitioner. The clinical psychologist is not eligible for the EHR Incentive Program, but the psychiatrists are. So, as you do describe, we are aware of the reporting burden differences. But those are, unfortunately, not something we can control or mitigate in our current configuration. The uniqueness of your practice is clear. But due to the different programs and eligibility requirements, those also then come with different reporting processes, and they are not fully aligned at this time. There are — may be opportunities for your two practitioners to do the group reporting. But that

will most likely not meet the EHR incentive eCQM requirements. That is — that is a gap that some practices such as yours have described in the past.

Gary Minnier: OK, so, thank you. It's nice to know we're not alone in what we're understanding. I guess one of my thoughts before I came into the call was that because the two psychiatrists are meeting Meaningful Use and we're attesting to them for Meaningful Use that — would it be possible to not include them in the group and allow their PQRS to be submitted individually as we attest for Meaningful Use, but for our clinical social workers and clinical psychologists, include them as a group, and then we can just submit the PQRS simply for that group, you know, that are the ones that don't fit for both.

Molly MacHarris: This is Molly. So, no, you can't unfortunately. So if you sign up to be a group practice, every provider that under that TIN is part of the group, so …

Gary Minnier: That's right.

Molly MacHarris: … so for those providers — so the psychiatrists who are eligible to participate in Meaningful Use, they can go ahead and attest to all of the objectives and they could still attest to the CQM. The pieces that their data would still be included, if you sign up to participate as part of a group practice. So essentially, what you would be doing is that you wouldn't be "reporting once," you would be reporting twice here to CMS.

Gary Minnier: OK.

Molly MacHarris: For two providers.

Gary Minnier: OK. Sure. OK, I think that makes sense then. Thank you.

Molly MacHarris: OK, thank you. Have a good day. Bye.

Operator: Your next question comes from the line of Joy Carr.

Joy Carr: Yes. OK. We do the billing for emergency physicians and, again, this is a specialty that there's not a lot of measures that cover ER physicians. And so, what is our option? I've called the QNet, you know, QualityNet Help Desk, and they just tell you to read something. They don't really help that much.

Molly MacHarris: This is Molly. So thank you for that feedback related to help desk, that's something we will work with them on. So if I heard you correctly, it sounds like your practice — you have a mix of both physicians and then other types of practitioners, is that correct?

Joy Carr: No, no just physicians, just emergency physicians.

Molly MacHarris: OK, so we actually do have quite a few number of measures that do apply for emergency physicians. We don't have — unfortunately, we don't have the measures specifications in front of us so I can't rattle them off …

Joy Carr: Um-hum.

Molly MacHarris: … but if you …

Joy Carr: Well, I found eight — I found eight.

Sophia Autrey: OK.

Molly MacHarris: OK.

Joy Carr: But that's not enough. And they're not under all three domains. So we just have to do the best we can?

Sophia Autrey: OK, so this is Sophia. So, if you found eight that are specific to emergency medicine, and did you review the specialty measure set?

Joy Carr: No, no, I don't know anything about that. Where is that?

Sophia Autrey: OK, so for some of the top reporting specialties, we actually have on our website a list of preferred measures for the specialty measure set. So you can go on the PQRS website under the Measures and find Emergency Medicine Specialty list, and you can look at the …

Joy Carr: OK.

Sophia Autrey: … measures included in that. And I don't want to be remiss in identifying that you can also look at the cross-cutting measures list to see if there are any measures in that list that are applicable as well.

Joy Carr: OK. And can I get one thing cleared up? You all mentioned — I mean, we thought we have been doing individual claims for our physicians, and we understood that it was only Medicare Part B, you know, the original Medicare, Medicare Mutual of Omaha. And then today I heard you all say something about any patients.

Molly MacHarris: Sure, so this Molly. So that doesn't apply for the claims-based reporting option. Under PQRS, we have five or six different reporting options. So if you are reporting via claim, of course, you would only be reporting on Medicare claims.

Joy Carr: OK.

Molly MacHarris: But if you are reporting using your EHR, that would include Medicare and then other payers as well. But since you're reporting via claims …

Joy Carr: Yes.

Molly MacHarris: … that would only be for Medicare patients.

Joy Carr: OK, then it makes sense. Thank you so much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Ann Swartout.

Ann Swartout: Hi, yes, I have a question. I work for a billing service. So we do, of course, lots of different doctors' specialties. We have a couple of doctors, one that does just the EKG interpretations and another vascular surgeon doctor who just does the interpretations at the vascular lab. So we're only billing for the interpretation component, and we do do this by claim. Our question is, do these — when they're for the interpretations only because you're limited on any data, do these still require PQRS codes or do we just bill them — we don't have to worry about that part of it?

Sophia Autrey: Hi, this is Sophia Autrey. So I want to say, yes, but I think it depends on everything else that they're doing. So are you saying that these vascular surgeons only do the review of information? They don't directly have — encounter or contact with the patient?

Ann Swartout: Correct. They're going — both doctors, one does the EKG interpretation only and the one vascular does strictly — it's your scans. So, you know, to read the scans and dictate the report of what he sees on the scan.

Sophia Autrey: OK.

Ann Swartout: So it's nothing else. They do not have face-to-face contact with anybody. They come in at the end of the day and they do these interpretations.

Sophia Autrey: OK. So there are still codes that they can report on for the measures, so they would still need to report.

Ann Swartout: Oh, my gosh. We were told we didn't have to when it's interpretation only. I mean because you're so limited. I don't know. This is getting really complicated.

Sophia Autrey: It is very complicated, and we apologize for that. But if you want to call the help desk and identify which specific codes they actually report, then the help desk should be able to help you with what measures would be applicable for them.

Anne Swartout: OK. Then I only have one other question. And we have called the help desk, I am listening to everybody's questions and answers, and believe me, we have called five times and gotten five different answers. I have a family practice doctor who has an EHR/EMR system, and they are set up with the Meaningful Use Incentive Program. I do the billing for them, you know, outsourcing —they outsource the billing to us. We do the billing via claims. Now, in that case, I'm still required to report the PQS — PQRS codes? And if they need anything, am I understanding this correctly, then they go back to the Meaningful Use and check it? I mean I'm not quite getting this.

Molly MacHarris: This is Molly. So the Meaningful Use Program and the PQRS Program, they are separate programs. I mean, what we covered in the presentation today was an option available to providers on reporting once. Since it sounds like for this particular scenario you provided to us, this provider — that provider's reporting via claims. Reporting via claims for PQRS does not count for Meaningful Use. So that provider would need to separately attest to their Meaningful Use objective and their CQM.

So I mean, I think, the main point that we want to drive home from the presentation today and, you know, for you and the other callers as well, is that providers have options. They have many, many options on how they can participate. If they choose the options that we talked about during the presentation today, they can reduce burden upon themselves by reporting once. But it's simply an option, and it's not something that may work for every single provider. I hope that helps.

Anne Swartout: So what you're saying is, she can go ahead — and because they've already set up for the Meaningful Use incentive, that's reporting one way, but me, as the biller, I still should submit it as the PQRS code because they're not set up with the registry and they don't do the billing in-house, correct?

Molly MacHarris: Yes, if that is what the provider would like to do, they can definitely do that. That is an option to them.

Anne Swartout: OK, because – yes, we didn't realize that we — OK, that answers that.

Molly MacHarris: OK, thank you.

Anne Swartout: OK, thank you.

Additional Information

Aryeh Langer: And unfortunately, that's all the time we have left for questions today. If we did not get to your question, you can either email or call the QualityNet Help Desk that's been referenced many times on slide 19 of today's presentation. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

Just a reminder, on slide 23 regarding the continuing education credits that are available for today's call. Also, an evaluation slide — on slide 22, you'll find more information and a URL to evaluate your experience with today's call. As a reminder, evaluations are anonymous, confidential, and voluntary. And we hope that you take a few minutes to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer here at CMS in the Provider Communications Group. I'd like to thank our presenters and also everyone on the line today for joining us in today's MLN Connects Call.

Finally, we have a call coming up next, I believe it's April 15th, and there'll be information coming out in the MLN Connects eNews regarding that call. So just keep an eye open for that or the other way you may have heard about today's call. Thank you so much. Have a great day.

Operator: This concludes today's call.

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