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

Disclaimer Page

Operator: At this time, I would like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing National Provider Call -Million Hearts Initiative. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed.

If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Geanelle Herring.

Thank you, ma'am. You may begin.

Introduction

Geanelle Herring: Thank you, Holley. Hello, I am Geanelle Griffith Herring from the Provider Communications Group here at CMS, and I will serve as your moderator for today's National Provider Call. I'd like to welcome you to the Physician Quality Reporting System and Electronic Prescribing Incentive Program, National Provider Call on the Million Hearts Initiative.

Today, we will provide you with an overview of the Million Hearts Initiative and the collaboration between the initiative with the Physician Quality Reporting System. We will have a question and answer session that will allow you time to provide input and ask questions. Before we get started, there are a few items that I would like to cover.

There is a slide presentation for today's session. At approximately 12:33 PM Eastern Time, a link for this presentation was e-mailed to all registrants. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Call's Resource Box.

Also, I'd like to point out that in advance of today's call, a listserv message with all of the announcements that you will hear shortly were sent to you. This call is being recorded and transcribed. An audio recording and written transcript will be posted to the Physician Quality Reporting System Web page.

Once on that page, select the CMS Sponsored Calls tab on the left side and find – then, you will find the entry for today's call, as well as all post-call

materials will be located there. I'd like to also thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help prepare slides and remarks for today's presentation, as well as for future National Provider Calls.

At this time, I'd like to introduce our CMS presenters for today. We are pleased to have with us Dr. Janet Wright, MD, FACC. She's the executive director of the Million Hearts Initiative, a CDC and CMS Innovation Center collaborative.

Also, Dr. Daniel Green with the office of – Office of Clinical Standards and Quality. It is now my pleasure to turn this call over to Diane Stern – excuse me, now turn the call over to Dr. Daniel Green, who will provide us with a few brief remarks. Dr. Green?

Daniel Green: Thanks, Geanelle. Welcome everybody to today's call. We really appreciate your interest in the Physician Quality Reporting System and Electronic Prescribing Incentive Programs and we appreciate your time and attention to today's call.

We're – as Geanelle mentioned, we're especially lucky today in that we have Dr. Wright from the Centers for Medicare and Medicaid Innovation, who will be doing a short presentation on the Million Hearts Campaign. This is a – this initiative was launched by the Department of Health and Human Services. And, again, we appreciate everyone's attention and we hope you guys will decide to participate in this initiative as we do feel it's very important and that it can help a lot of our beneficiaries.

So, the – as many of you know, the Millions Heart – the Million Hearts Initiative enhances cardiovascular disease prevention activities with proven, effective, and inexpensive clinical and community interventions. And, again, Dr. Wright will be going over this in more detail about the program.

In order, however, to make sure that folks have plenty of time for questions, I'm going to limit my remarks and turn the meeting over to Diane Stern for

some announcements and then we'll start with the presentation. Again, thank you all for your interest and then for dialing in today.

Announcements

Diane Stern: Thank you, Dr. Green. First announcement will be on the Communication Support page. On March 1st, 2012, Centers for Medicare and Medicaid Services, re- opened the Quality Reporting Communication Support page to allow individual eligible professionals and CMS selected group practices the opportunity to request a significant hardship exemption for the 2013 electronic prescribing payment adjustment.

The Communication Support page will accept hardship exemption requests now through June 30th, 2012. The Communication Support page can be accessed under related links on the homepage of Physician and Other Health Care Professionals Quality Reporting Portal. The Web address for that portal is https://www.qualitynet.org/portal/server.pt/.

A user manual is available to assist individual eligible professionals and CMS selected group practices in submitting their request for a hardship exemption. The user – the user manual can be accessed through the help icon on the Communication Support page.

For additional information on the 2013 e-prescribing payment adjustment including who is subject to the payment adjustment and how to avoid the payment adjustment, visit the Electronic Prescribing Incentive Program Web site at www.cms.gov/erxincentive and you can go to the – you would select the Payment Adjustment Information Section page on the lefthand side of that Web site.

Typically, eligible professionals should view the MLN Matters Article SE1206: 2012 e-Prescribing Incentive Program to reach your payment adjustment.

The next announcement will be on the feedback report request process. Please be advised that the alternative feedback report request process, which

enabled individual eligible professionals to request their NPI level feedback reports through their carrier /MAC ended on March 16, 2012.

This was the last day carrier/ MAC would have accepted request for Physician Quality Reporting System and e-Prescribing Incentive Program feedback report. Individual eligible professionals can request their NPI-level feedback reports through the Quality Reporting Communication Support page.

The next announcement will be on the 2011 e-prescribing 10-month feedback reports.

TIN-level interim 2011 e-prescribing feedback reports are available for 2013 payment adjustments on the portal. Please note that TIN-level reports on the portal require an individual authorized access to CMS computer service, better know as IACS account. Eligible professionals can request their individual NPI-level reports by submitting a request via the communication support page.

The next announcement will be on EHR submission. CMS would like to remind all eligible professionals that the PQRS portal for program year 2011 EHR submission is now open. Eligible professionals have until April 30th, 2012, to submit their EHR data. Additionally, all eligible professionals submitting EHR data will need to obtain an IACS account.

Additional information related to obtaining an IACS account can be viewed on the Quick Reference Guide, which is located on the homepage of PQRS portal. Again, that Web page for the portal is https://www.qualitynet.org/portal/server.pt.

I will now turn the announcement presentation over to Lauren Fuentes.

Lauren Fuentes: Thanks, Diane. CMS would like to alert eligible professionals that we recently identified an error related to the submission of measure number 235, Hypertension: Plan of Care for the 2012 Physician Quality Reporting Systems. Hypertension: Plan of Care is a claims/registry measure with six G-codes and one CPT II code that are inactive due to an error found on the

HCPCS tape. Consequently, this has resulted in claims containing the G-codes or CPT II code associated with the measures to be rejected by the carrier/ MACs or denied.

The G-codes, which are G8675, G8676, G8677, G8678, G8679, G8680, and the CPT II code, 4050F, will be reactivated with the next update of the HCPCS tape in April 2012. For 2012 claims-based reporting, the Physician Quality Reporting System requires at least 3 measures to each be reported at a 50 percent reporting rate. In the interim, eligible professionals who had intended to report this measure via claims for the 2012 Physician Quality Reporting System may want to consider taking the following steps.

Eligible professionals may want to consider reporting additional measures to substitute for number 235, Hypertension: Plan of Care. Also, Hypertension: Plan of Care, again, is a per visit measure, which requires reporting for 50 percent of eligible patient visits. Therefore, eligible professionals could report the measure on more than 50 percent of eligible professionals from April through December 2012 to increase the likelihood for successful reporting of the measure.

We would like to remind eligible professionals to check the CMS Web site spotlight page for recent updates on both the Physician Quality Reporting and eRx Incentive Program Web site.

Our next call, our next National Provider Call will – is scheduled for April 17th, 1:30 to 3 PM, Eastern Standard Time and the topic for that call will be the 2011 eRx 10-month feedback report.

So, at this time, I'd like to turn the call over to Dr. Wright for our presentation on the Million Hearts.

Dr. Wright?

Presentation

Janet Wright: Thank you so much and thank you all for joining in the middle of a busy – I'm trying to check the time zone. Some of you are certainly still in the morning of your workday, and thank you to Dr. Green also for extending – and the CMS staff – for extending this opportunity to share Million Hearts with you. I'm going to be working off a slide set and I'm looking now at slide number five.

I want to introduce to you, actually on slide number six, the goal of Million Hearts. It is, as Dr. Green mentioned, an initiative of the Department of Health and Human Services. It's co-led by the Centers for Disease Control and Prevention and Centers for Medicare & Medicaid Services.

It has a very explicit goal and timeline. And in that respect, you will see the fingerprints of its architect. Those being Dr. Frieden, the director of the CDC; Dr. Berwick, our previous administrator at CMS; and also Dr. Farzad Mostashari, who's the National Coordinator for Health Information Technology.

So, I will walk you through what this initiative intends to do. But, specifically, the goal is to prevent a million heart attacks and strokes in five years. That timeline is quite explicit.

The clock started ticking in January of this year and we're going to count prevented events all the way up until January 1st of 2017. I'm on slide seven now. And what slide seven shows is the impact that heart disease and stroke has on the country.

Cardiovascular disease, as you see, causes one out of every three deaths to a million heart attacks and stroke each year and over 800,000 deaths. It kills on both sides of the 65-year marks – younger people, as well as older – leaving holes in our families and our communities. But it is also extremely expensive for the country in terms of the cost of treatment and the loss in productivity.

The other thing we note is that, although, this hits both genders, it hits races unevenly. African-Americans, for example, lose over 14 months of life

expectancy to cardiovascular disease compared to some of the other causes of that shorten lifespan. On slide eight, I think to this point what I've tried to do is establish cardiovascular disease as a major problem for the country.

The other thing about cardiovascular disease is that we are blessed to have a strong evidence base to tell us what the effective treatments are to prevent heart attacks and strokes. Although, new science is always welcome, we do have a strong scientific foundation for the intervention and treatments and lifestyle changes that can actually help prevent or control problems that lead to heart attack and stroke. The issue then is not new science.

It's actually doing the things well that we know are effective. And on slide eight, you see that as a population across the country, we are still not achieving even 50 percent performance on very basic, scientifically sound interventions. So, on the slide here, you see that only 47 percent of people who should be on aspirin to prevent a cardiovascular event are actually taking it on a regular basis.

And on down the slide with blood pressure control, cholesterol management. And the one, frankly, that scares me the most, or that disappoints me the most, is that the denominator under the smoking element there are those who've already put a stake in the ground as deciding to quit smoking and only 23 percent of those folks are being offered the counseling and the medication therapy that has been shown to be effective. So, we got a big problem for the country.

Big in terms of its impact on us personally, individually, and then our communities, very big in terms of the economy. We have good science and yet we are underperforming. So, that is why the federal government has gotten involved in initiating a – this work to prevent heart attack and stroke.

I will tell you, though, that this initiative is about much more than just raising awareness of the problem. This initiative is about inviting and activating groups who can profoundly change the heart health of the country, and that's why I'm so glad that you all are on this call today because you are soldiers in that army. I'm going to move to slide nine.

Here, you have how Million Hearts is approaching preventing a million heart attacks and strokes. Even though this goal is audacious, we have every intention of getting there. And on this slide, you see clinical prevention and community prevention as two lanes of traffic, if you will, that we expect to merge over the five-year period.

What I mean by that is that right now public health works and clinical practice works are in most communities around the country quite separate. Through focusing on a common goal, preventing heart attacks and strokes, we anticipate that the efforts and ongoing works and future activities of public health and clinical practice are going to come together in a very effective way. But right now, they're separate.

So, I will show you to the right, you will see those icons. The community efforts are focused on ridding the environments and our workplaces and our homes of tobacco use and smoke, reducing salt in the food, and eliminating artificial transfats in the food supply. Those are all population-level and community-focused activities, many of which are going on at the CDC and the FDA in cooperation with the food industry. Over on the clinical side, and I'll spend more time on these considering what you all do for a living, clinical side is also focused but focused in three areas.

The first on the ABCs, as I mentioned, calling the attention of the healthcare professionals and the systems in which they work to the power that they have along with the people they are taking care of to actually, in a short period of time, prevent heart attack and stroke through focus. The second is fully deploying health information technology. And the third is in policy work and practice work around new models of care.

So, I'll move to slide 10. I'm going to go through fairly quickly the community-based and population-based interventions, which are extraordinarily powerful. The first is around tobacco.

Some of you may have already seen the tips from former smokers. It's this part of the campaign constructed by the Centers for Disease Control and

Prevention and just launched this past week showing actual smokers and the impact of tobacco on their lives. Other things mentioned besides mass media campaigns on this slide are the policies for workplace and public places making those smoke-free.

And then, there are 61 communities around the country that have received some grant funding to help work on tobacco-free living. So, to give you a couple of examples of how this can be effective, on slide 11, you will see raising the price of cigarettes through excise taxes. This is in New York City and New York State from 2000 to 2010.

This is not the cost of a pack of cigarettes. It's actually the taxes on cigarettes. So, you see enormous increase over a fairly short period of time.

And if you will just keep a visual of the slope of that slide as we move to slide 12 where you see a dramatic drop in smoking in New York City over the same time period. As you see, the smoking rate for adults was static for a number of years, but with the combination of policy changes and the ability to offer free patches and release these hard-hitting media campaigns, you see a dramatic drop, which resulted in 450,000 fewer smokers.

I could add a line that shows the reduction in smoking in youth under the age of 18. It's very similar and along the same timeline. Very powerful policy change.

So, on slide 13, we will start on the clinical side. So, the community efforts are really targeted toward reducing the number of people who need treatment because the – those community interventions affect the population. For those who do need treatment, our efforts are directed towards optimizing the quality, making sure there is access and improving the outcomes.

So, I'll move to slide 14 and it's particularly relevant for our topic today about the PQRS measures and the eRx incentive program. Our goal here is to create a uniform set of measures for the ABCs. So, they are reported the same way and can be used with great facility and with very little burden.

We know that these measures have a very tight correlation to the outcomes. So, high performance on the ABCs is directly related to reducing the risk of heart attack and stroke in our – in our citizens. We want to move to a system where the ABC measures or the data used to collect the – or the data used to calculate those measures is extracted within the workflow.

So, this is not something that all of you get stuck with at the end of a long day with a stack of charts and everyone else has gone home. But it actually occurs within the flow of care. And then, we want to link high performance on the ABCs to incentives including recognition and reimbursement.

On the next slide, 15, health – what do I mean about deploying health information technology? How can that help us get better outcomes? Well, now, and there is increasing buzz about this, we're asking our professional community to take care of a population of people.

And it's true that all of us who do clinical care, and I have in the past, take care of one person at a time. It's the way the interaction occurs and it should be. However, if we were trying to make our care overall better, we have to know how we're doing with a population of people, say, with high blood pressure or with heart failure.

And to do that, you need the registry function built in to your electronic medical record or to – freestanding in some other form of technology. Also, to take care of everyone and make sure you don't miss an opportunity to treat them, we need decision support within the flow of care. And these are the smart type physician reports – decision support that reminds you that it's time to titrate a medicine or it might be the third visit where a blood pressure has remained elevated.

For those of us who take medications or are trying to be heart healthy, electronic reminders that tell us it's time for refill or time to get a blood test checked or time to take a walk. Those electronic reminders can be profound behavior change agents and Million Hearts is working to get those embedded into systems where they're most effective. So, we'll move to slide 16.

We live in a time where – a really historic time where new care models are being launched. Health homes or accountable care organizations, bundled payments, patient-centered medical homes, and others. We were working to get the ABCs embedded in those new models and to make sure that a high performance is incentivized.

In addition, there are a number of perhaps less traditional team members who are powerful and effective change agents. Those include pharmacists, cardiac rehab teams, health coaches, lay workers, peer wellness specialists, or those who have recovered from mental health issues and now are able to help others cope and stay on their medications as prescribed and gradually move toward healthier behaviors. So, the idea is that as new models are launched, let's make sure that we are making full use of everyone who can help us move toward heart health.

On slide 17, I just want to show a couple of slides. These are programs that are currently underway within CMS that have and will continue to have a profound impact on preventing heart attack and strokes. When we looked all across the federal family for ongoing work, it turns out there were 47 to 50 separate programs that can affect stroke and heart attack rates.

Our work is to work with the data analyst and the people that are leading these programs, make sure that we have taken every opportunity to embed the ABCs and to embed incentives toward high performance on the ABCs and other behavior change that will reduce heart attack and stroke. And that while new – and when new programs are being developed, that we keep Million Hearts' goal ever present in the minds of those who are designing those programs to take full advantage. So, on slide 18, you see additional from Medicaid, at least five programs there.

And then, on slide 19, additional ones in the Innovation Center and in the fairly new Medicare/Medicaid coordinating office. And then, again, this is just a subset. So, on slide 20, I'll circle back to getting to goal.

You see there, the ABCs. Under baseline, you see our current performance across the population. By January1st of 2017, we want to move to the levels of performance you see there under target.

Under clinical target, that number is higher because it refers to the population of people who are currently in clinical healthcare systems, and of course if compared to folks who are not in a relationship with a doctor, nurse, or clinic, we're holding those who are already in those clinical systems to a higher performance level. So, on slide 21, it reminds to say that everybody has got a piece to play in getting to preventing a million heart attacks and strokes.

I know that all of you are representing practices or health systems, hospitals, and other parts of the healthcare system. But, you know, at night when you go to sleep, you're representing yourself and you're concerned for your own health and that of your family and those you love. Individual commitment means everything to us because we think that's where the most powerful change will occur is that each of us commits to being more heart healthy and supporting heart health in our families, our organizations, worship places, and others. So, I will ask you to think about what commitment you can make.

And on slide 22, you will see that this is across the federal family. Every one of these agencies has ongoing problems, ongoing – sorry, ongoing programs that are contributing to preventing heart attack and strokes. It is a privilege to get to know the individuals that are leading these programs and the commitment that they have made.

On 22, you see a subset of the private sector organizations that have also made commitments. And I'd ask you to go to the Web site I'll reference in a moment and you can actually click on the icons for these organizations and find out what their commitments are. What we're discovering so far is that new partnerships are forming among those who have made commitments.

And they wouldn't have known about the body of work that each of these has ongoing if they have not made their commitments public. So, we are finding all kinds of new opportunities to work together. And in an environment of limited resources, that's extraordinarily valuable.

So, I just want to give you a peek into what I hope will be just the near future, not the long-term future but in the near future. Lower sodium foods are actually abundant and they are everywhere. We actually prefer them. It turns out that our taste buds adjust in a period of 5 to 12 days and we no longer like higher sodium foods after that transition period. Secondly, blood pressure monitoring is not something that only occurs in a medical setting. It actually starts at home because blood pressure cuffs are ubiquitous. They are everywhere. They are easy to use. The readouts come in red, yellow, and green along with the numbers if people want numbers.

And, more importantly or as importantly, when a blood pressure reading is taken, the individual whose arm is in that cuff can designate that the reading be transmitted to the professional of his or her choice. So, that we're loop closing. We no longer take measurements and let them get scribbled on a piece of paper that then gets crumpled up and never returned to a professional.

So, that – so, that someone seeking advice for blood pressure control can get that advice when and where and how they need it. If they want it over the Internet, if they want it on a phone call, if they want through written mail, or in an office visit. And then, finally, there are no or low copays for medications.

And the reason is that we finally acknowledge that treating high blood pressure aggressively and thoroughly not only saves lives but it actually saves money. So, this is not a fantasy. It turns out studies have shown that adding a Web-based pharmacist care program to home blood pressure monitoring increases the control of blood pressure by over 50 percent.

And that study actually confirmed that in folks whose blood pressure was the highest. So, in those at the greatest risk. So, on the final slide, it reminds me to ask you to go to the Web site listed here.

This is a place to pledge individually and also as organizations. The individual pledge means basically that you will make your personal effort and

contribution to preventing a million heart attacks and strokes. We count these pledges on a daily basis.

They mean everything to us. If you sign on as an organization, we will be coming back to you to find out what specific things you are willing to do to help prevent heart attack and stroke. So, thank you.

I think I'm going to turn it over to Dr. Green.

Daniel Green: Thank you, Dr. Wright. I just want to thank you not only for your terrific presentation and overview of the Million Hearts Initiative but for her tremendous work on this project. As you can see by the numerous stakeholders that we have that are now partnered with HHS in this endeavor, it's pretty magnificent, the work that she's done in a relatively short time since joining CMS.

So we're all thankful that she's here and the great work that she's doing. Picking up in the presentation on slide 27, I'm going to relate the Million Hearts Initiative, if you will, to the Physician Quality Reporting System. And for – one of our goals in 2012 was to implement the – or make sure all the measures that are reportable for the Million Hearts Initiative are reportable in PQRS.

Early on, we decided that we need to have us a standard set of measures across HHS if we're going to gain any traction with this program. So, with folks from the CDC, from the ONC, from HRSA and other HHS agencies, we got together and we came up with a list of measures that we had either in the program or added to the program that we felt would be instrumental in our first version of the Million Hearts Initiative. So, if you look on slide 28, you can see the measures that we do have in the 2012 Physician Quality Reporting System.

For the EHR portion of that program, we've called these four measures. And while it's not mandatory to report these measures, we do want to encourage folks that are reporting directly from an EHR to please consider reporting on

these measures if you believe that they are pertinent to the care that you provide. And you can see the measures listed again on slide 28.

The actual – which measures they are. And you can see that the majority of them are all reportable via claims, registry, and electronic health record. However, if you notice, PQRS measure number 316, which is a preventative care and screening measure, that measure is actually only reportable via an electronic health record.

And part of the reason behind that is, it's a little bit of a complicated measure, not for providers to report, but it's a little complicated in terms of the calculations because it takes the patients' risks and risk factors into account when calculating the appropriate LDL for that particular patient. So, it is a risk-stratified measure. And, again, it is only reportable via EHR.

So, we're kind of excited about that measure. Something else I want to bring up is, you can see on the bottom of slide 28, is the cardiovascular prevention measures group. This measures group is reportable via claims and registries and it contains the measures listed under the measure titles.

So, that will be measures 2, 204, 226, 236, 241, and 317. So, these, again, would account for aspirin use, blood pressure control, counseling regarding smoking and also LDL control. Now, the LDL control here is associated with particular diseases.

And that's because these were the measures that were available to select from at the time the program was put together. We would, again, encourage folks to be able to report on this. As you know, measure groups should report – it only requires you to report 30 patients.

They need not be consecutive and there is a G code if you've done all the quality actions. Say you'd only to report actually one G code if you've done all the quality actions for these measures. As always, of course, we encourage folks to participate directly from their PQRS-qualified EHR, if they have one.

And last slide, slide 29, just gives you some more information. If you have questions that we haven't answered, certainly you can ask them on the call. But if for whatever reason, you know, we don't get you on the call, please feel free to contact our QualityNet helpdesk and that information is available on the last slide.

As you know, they are 7 AM to 7 PM Central Time, Monday through Friday, and their number is 866-288-8912. So, just before we go to the question and answer session, I just want to reiterate one announcement that Diane Stern made earlier in the present – earlier in today's call and that was around the submission timeframe for the electronic health records. As Diane noted, the submission period is 4/30 of 2012. So, it ends April 30th of 2012.

That is a change from the initial information that we gave when we stated that the portal would close on March 31st of 2012. We have extended it by an additional 30 days at the request of several vendors as folks are trying to get their IACS account – excuse me, their IACS accounts and have desire to participate in the 2011 PQRS program directly from their EHR.

So, we're encouraged by that and we would – we would also like to suggest that as many folks that have he PQRS-qualified system do report in, get your IACS account, work with your vendor if it's qualified system, and do report if your 2011 information is done.

As we said, we've extended the portal to April 30th. Again, that's only for EHR direct. The registry submission still closes on March 31st.

So, thank you all for your time and attention. I will turn it back over to Geanelle.

Polling

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

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

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

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

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

Please hold while we complete the polling. Please continue to hold while we complete the polling.

Geanelle Herring: While we're holding, let me take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of the organization that you represent. In an effort to get as many of your questions as possible, we ask that you limit your questions to just one.

Holley when you're ready, we're ready for our first question.

Question and Answer Session

Operator: Thank you for your participation. We will now move into the Q&A session for this call. To ask a question, please press star followed by the number one on your touchtone phone.

To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your

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

Please hold while we compile the Q&A roster. And your first question does come from the line of Marion Armstrong.

Marion Armstrong: Hello, this is Marion Armstrong.

Daniel Green: Hello.

Marion Armstrong: Hello. My question is that a provider only sees nursing home patients in the nursing home. He cannot use the eRx because the nursing home orders all the meds. How can he be excused from the penalty?

Christine Estrella: Hi, this is Christine Estrella. I will answer your question. So, for the 2012 payment adjustment, the deadline for submitting a significant hardship request has passed; that adjustment is currently being implemented.

But for the 2013 payment adjustment that is one of the categories that is eligible professionals can actually apply for if they wanted to be exempted from the 2013 payment adjustments. So, if an EP was under that situation and EP could go in towards Communication Support page and the link to that is available on our Web site. It's www.cms.gov/erxincentive and that there are payment adjustment links – there is a payment adjustment section on there and the Communication Support page link is on there.

And I believe the – there is a manual out there that kind of goes through how to fill out the form on the Communication Support page and there are a couple of buttons that you'd be required to enter into as well as your contact information. And the deadline to submit that request is June 30th, 2012, for the 2013 payment adjustment.

Marion Armstrong: OK. We reviewed that, but we didn't quite understand what category we could fit in. But do you think the manual might be helpful?

Christine Estrella: Yes, the manual would be helpful and, actually there is a difference between – I don't know if you have submitted a request last year for the 2012 payment adjustment, but this year we beefed up that Communication Support page a little bit.

So, there should be actually a category for EPs who are in nursing homes.

Marion Armstrong: OK. All right. Thank you.

Christine Estrella: No problem, and feel free to call us via the helpdesk if you're running into issues or you can't find the section that you're supposed to apply to.

Marion Armstrong: All right. Thank you.

Geanelle Herring: Thank you for your question, Ms. Armstrong. Next question, Holley?

Operator: Your next question comes from the line of Mary Koval.

Mary Koval: Hi, good afternoon. This is Mary Koval from Weill Cornell Physician Organization, and I apologize for this basic question. But I've just gotten very confused over the last month on the 2013 penalty adjustment.

I just want to confirm that our physicians will receive a payment adjustment in 2013 if they did not e-prescribe for the calendar year 2011 25 e-prescriptions or they didn't – unable to e-prescribe 10 prescriptions from January through June 2012. Is that correct?

Christine Estrella: That's – sure. That's actually our reporting criteria that you mentioned that we had QAs that you can report the measure. So, the one past last year that you mentioned and the other one is this year that we had to report at e-prescribing events via claims only through June 30th, 2012, to avoid the 2013 payment adjustment.

We also have some including criteria, so now, as you know, the payment adjustment wouldn't apply to you for payables you had less than 10 percent of your Medicare allowed charges that comprised of denominators, billing codes, and some of the other measures.

And we also have – another option is that you feel that you are experiencing a significant hardship in terms of reporting the measure you're e-prescribing. Then you could request a significant hardship exemption under our Communication Support page.

Mary Koval: OK.

Christine Estrella: So, if you think you were – you're included or you could report or you could submit an exemption request.

Mary Koval: OK, and the exemptions of last year, which you mentioned, the 10 percent of the Medicare population, but also there was one less than 100 Medicare patients in a six-month period and there's a new one that says less than 100 prescriptions in a six-month period. Those are two valid exemptions as well, right?

Christine Estrella: Yes, those are, you know, the payment adjustment would not apply to you.

Mary Koval: OK.

Christine Estrella: Either of those, you know, applied to your practice.

Mary Koval: OK, great. OK, great. Thank you so much. I appreciate it.

Thank you.

Geanelle Herring: No problem. Thanks for your question, Ms. Koval. Holley, we'll take our next question.

Operator: Your next question comes from the line of Elizabeth Rich.

Elizabeth Rich: Hi. We were successful eRx submitters in 2010 and 2011 and I wanted to clarify for 2012, '13, '14, since we were – we are all set for 2011, we don't need to worry about the 10 eRxs through the first half of this year. Is that correct?

Or is it the same this year at 10 in the first half of the year, 15 in the second half of the year?

Christine Estrella: If you met the criteria for the 2011 incentive, then you would be off the 2013 payment adjustment. However, you know, if you feel that you didn't meet the criteria, you don't have to report this year through June 30th with that new criteria that I mentioned for the 2012, the 2012 reporting period.

I do encourage you, though, to do report this year, just because we do have a 2014 payment adjustment. And if you wanted to report this year for the incentive, reporting for the 2012 incentive. If you reported successfully for that, you would get off the 2014 payment adjustment.

Elizabeth Rich: OK. And the 2012 requirement is also 25, correct?

Christine Estrella: Yes, the requirement is 25 for denominator-eligible cases.

Elizabeth Rich: OK. And it's not split 10 and 15 like last year?

Christine Estrella: No, it's not.

Elizabeth Rich: OK.

Daniel Green: Both.

Christine Estrella: Well, I mean.

Daniel Green: It is if you need to get out of the 2013 penalty. But if you were successful in 2011, then you should be exempt from the 2013 penalty. In which case, you would just need to report 25 times during the course of the year.

Elizabeth Rich: OK, perfect.

Daniel Green: Both could earn you an incentive, again, provided you're not participating in the Medicare and EHR incentive program and also that you have 10 percent of your charges comprised of codes in the denominator of the measure. That would – if you have at least 10 percent and you're not participating in the Medicare/EHR incentive, you would also earn a 2012 eRx incentive and

you'd be out of the 2014 payment adjustment. And, again, if you've already successfully done the 25 in 2011, that would get you out of the 2013 payment adjustment.

Elizabeth Rich: OK.

Daniel Green: So, you could put through the end of that program.

Christine Estrella: Yes, and remember that as the 2014 payment adjustment is the last adjustment that we have for the program. So, it would be good to credit reports to get out of the way.

Elizabeth Rich: OK. Great. Thank you so much.

Geanelle Herring: Thank you for your question, Ms. Rich. Holley, next question please.

Operator: Your next question comes from the line of Jenna Dewolfe.

Jenna Dewolfe: Hi, this is Jenna from META. I was calling in regards to measure 204 for the EHR reporting. And in that measure, the specifications only list – specifically list aspirin and I was wondering if there were going to be – if there is any like revisions or consideration of other things like Coumadin or Ecotrin or off name brands of aspirin.

Daniel Green: You mentioned that the EHR measure specifications.

Jenna Dewolfe: Yes.

Daniel Green: OK. So, whatever EHR measure specifications are currently posted for 2012 . . .

Jenna Dewolfe: Yes.

Daniel Green: . . . would be the measure specifications for 2012. We won't be having any changes to them.

Jenna Dewolfe: Right.

Daniel Green: I can't give you an absolute for 2013 at this point.

Jenna Dewolfe: OK. And part of the reason why I'm saying this is because of the Million Hearts project. It should – we're following for our reporting. We're following the EHR specification.

I don't know where to go with that. We just don't want to miss any patients who really are on a form of aspirin that just doesn't happen to start with the word aspirin.

Christine Estrella: So, if we are – if you are using this for purposes of participating in PQRS, you should try calling our helpdesk. They have our measure specs you should be able to claim and walk through with you which patients you should be reporting on.

Daniel Green: I'm sorry.

Jamie Welch: Hi Jenna. This is Jamie Welch. I just wanted to also give you information on the EHR downloadable. That resource table that's available. You may want to check under the Rx norm tab and see what other medications are listed under there. Just to make sure – I'm sure that it's a bigger, broader aspect of what aspirin could be and how it could be represented.

Jenna Dewolfe: OK, thank you. And then, also list in the measure specifications that they were prescribed the aspirin within the measurement period. Does that mean it's not including refills?

Daniel Green: No. Refills would count for that.

Jenna Dewolfe: OK, thank you.

Daniel Green: Thanks.

Geanelle Herring: Thanks Jenna Dewolfe. Holley, next question, please.

Operator: Your next question comes from the line of Fred Dietrich.

Fred Dietrich: Yes, hello. Thank you for taking the question. I'd submitted the question with my registration.

We had heard that some EPs had actually sent, during 2011 – they actually sent hundreds of scripts successfully through their e-prescribing services. But they didn't report them on their Part B claims. How they can get credit for that when they actually did well over a thousand prescriptions during the year?

Geanelle Herring: Can you hold while we confer with the speakers, please?

Fred Dietrich: I'm sorry. Can you hear my – did you hear my question?

Geanelle Herring: We did, sir. We're going to confer and we'll come back . . .

Fred Dietrich: OK.

Geanelle Herring: . . . with an answer, so hold on.

Fred Dietrich: Oh, I'm sorry. Thank you. I'll wait for your response.

Aucha Prachanronarong: The requirement of this program is that the – the e-prescribing activity has to be reported to us on your claims because, again, this is a program that provides an incentive for reporting on an e-prescribing quality measure. So, the basic requirement is, even though you e-prescribe in addition to that, you still had to submit on your claim the G8553 code indicating that an e-prescribing event was associated with whatever service was provided on that claim. So, I think, hopefully, that answers your question.

Fred Dietrich: Yes, but it's not a very good answer. The purpose of the program was to increase the use of the e-prescribing systems, which they have done very effectively. If it – doesn't seem fair that an oversight in their reporting would cause them the incentives. I mean, the incentives caused them to actually . . .

Dr. Rapp: Did you talk to them about the . . . ?

Fred Dietrich: . . . actually incur then the penalties since they really did meet the requirements, far above the requirements of the prescribing program.

Dr. Rapp: Are you talking about yourself or somebody else?

Fred Dietrich: I'm talking about other positions that we've – that we know in our user base.

Dr. Rapp: OK. Well, I think as who wants to explain that, that is the program requirement. If there is some particular element that do feel that the – I think that you're talking about people to whom the payment adjustment has applied to, correct?

Fred Dietrich: That's correct. Yes.

Dr. Rapp: Oh.

Fred Dietrich: Yes.

Dr. Rapp: The – if there are some questions or that these parties feel that the payment adjustment should not apply to them, what we're advising them to do is communicate that to the helpdesk.

Fred Dietrich: I see. Thank you very much. That would be a good solution.

Geanelle Herring: Thank you for your question, Mr. Dietrich. Holley, next question please.

Operator: Your next question comes from the line of Monica Clayton.

Monica Clayton: Hello.

Geanelle Herring: Hi.

Monica Clayton: I have a quick question about your Physician Quality Reporting System. We're actually a behavioral mental health facility and I believe that you had mentioned that some of these components do not necessarily have to be reported. At this point, as far as what I see from the slide, there is probably only just one, number 226, that we would be able to report.

Would that be adequate enough to prevent for the payment adjustment in the future and to get the incentive, or would we have to somehow figure out another way to do others?

Christine Estrella: So, for the – with respect to the Physician Quality Reporting System, we have a payment adjustment coming up in 2015. We haven't finalized in your requirement, however, for the reporting requirements – for that payment adjustment. So, the only requirements being finalized are for our 2012 incentive.

The reporting period is going on now. If there is only one measure applicable to you, you could report that measure for the incentive of your claim. You're just being subject to our measure applicability validation process.

However, I would check with our QualityNet helpdesk and talk to them to make sure that there are no other measures that apply to you, to make sure that that's the only measure you could put on which you could report.

Monica Clayton: OK. All right. Thank you so much.

Christine Estrella: Great. However, on this presentation slide and, yes, they have – they can walk you through your specific scenario to see if any other measures apply.

Daniel Green: And please be aware that these slides – these measures that are on this particular slide to which you are referring are only the measures that we have in our cardiovascular measures group and/or for the Million Hearts Initiative. There are over 200 measures in the Physician Quality Reporting System, several of which deal with mental health and depression, what have you. So we would encourage that you move also on our PQRS Web site at the full list of the measures because it's likely that others would apply to you as well. And, certainly, we would encourage you to and will offer you to report smoking measure.

But feel free to choose any three measures you like.

Monica Clayton: OK, great. Thank you very much.

Daniel Green: Thank you.

Geanelle Herring: Thank you for the question, Ms. Clayton. Holley, next question please.

Operator: Your next question comes from the line of Marsha Stufflebean.

Marsha Stufflebean: Hi, this is Marsha Stufflebean calling from St. Mary's Physician Billing Services, and I would like to know if you could repeat the Web site once more where we could find the hardship forms?

Christine Estrella: Sure. It's our e-prescribing Web site. So, it's www.cms.gov/erxincentive.

And under that there is a section entitled "Payment Adjustments" on the left. If you click on that – if you scroll down all the way to the bottom, there is a link to our Communication Support page. That's what it's called.

And there's also a user guide that you can use that right either above or below that link as well.

Marsha Stufflebean: OK. Thank you very much.

Geanelle Herring: Thank you for the question, Ms. Stufflebean. Holley, how many questions do we have left in queue?

Operator: We have three questions left in queue.

Geanelle Herring: OK, next question, please, Holley.

Operator: All right. Your next question comes from the line of Cheryl McNew.

Cheryl McNew: Hi, my name is Cheryl McNew. I'm with Tracy Orthopedics. I had started the eRx incentive.

And then, when Meaningful Use came in, I started that as well. And I was told at the meetings that you could only participate in one incentive. So, if you participate in two, they won't take it.

So, I automatically assume that, OK, I'm doing the Meaningful Use. I need to stop reporting for the eRx incentive. And now, you know, I get the 1 percent penalty for this year.

But I was never told that I needed to continue to report that.

Christine Estrella: For you...

Cheryl McNew: And now, when I – and I did report – I did send the e-mail to the quality, you know whatever it was. And they advised me, no, I still needed to continue to submit the G code in our claims and also, you know, continue with the Meaningful Use. CMS is going to choose the Meaningful Use since that's a higher reimbursement or higher incentive, is that correct?

Christine Estrella: With respect to the differences between the EHR incentive program and e-prescribing incentive program.

Cheryl McNew: Yes.

Christine Estrella: With the respect to incent – receiving incentive payments that I'm not talking with respect to payment adjustment or statutorily not authorized to provide you with two incentives. And for example, you participated in the e-prescribing incentive program.

Cheryl McNew: Right.

Christine Estrella: And you participated in the Medicare, EHR incentive program, it's different if you for participating in the Medicaid incentive program that statutory limitation wouldn't apply.

But with respect to the payment adjustment, the payment adjustment under e-prescribing incentive program still applied to an EP regardless of whether or not the EP were participating in the Medicare or Medicaid EHR incentive program.

And, in fact, I believe we – last year, September 6th, 2011, we actually finalized a rule where EPs were able to go in and submit a significant hardship request made on their participation under the EHR incentive program.

Cheryl McNew: OK. But I don't know, it still didn't answer my question. My question was, am I still – am I still able to report the G code and do the Meaningful Use and not get – and not get penalized for next year's claims?

Christine Estrella: You could still – you could report at the G code for purposes with the payment adjustment.

Cheryl McNew: Right.

Christine Estrella: So, let's not talk about – let's talk about the 2013 payment adjustment specifically.

Cheryl McNew: Right.

Christine Estrella: You're participating in the EHR incentive program.

Cheryl McNew: Right.

Christine Estrella: And we greatly thank you for doing that. But you'd also have to report our G code G8553 via claim.

Cheryl McNew: Right.

Christine Estrella: Pending the e-prescribing events to get out of the 2013 payment adjustment.

Cheryl McNew: OK. And just like the gentlemen stated before, you know, they qualified for it. They did it with the e-scripts just like we did.

But the only problem is, you know, because I was only concerned – and when you go to those classes, they specifically to tell you, no, you could only participate in one incentive program. They didn't clarify that we still needed to continue with the eRx or you will get penalized. So, you pick and choose which one you are going to participate in.

Christine Estrella: And . . .

Cheryl McNew: You know what I'm saying?

Christine Estrella: Yes, I understand what you're saying. But, actually, you can – you can participate at both. You just would receive the incentive for one or the other.

Cheryl McNew: Right.

Christine Estrella: But for some reason you qualified for both incentives.

Cheryl McNew: Right, OK. All right. I just want to make sure that since Meaningful Use's incentive is higher than the incentive for the e-script, I just wanted to make sure we would get reimbursed for the higher incentive.

Male: Now, the statute says that if you – again, the incentive under the EHR incentive program, you cannot get an e-prescribing one.

Cheryl McNew: OK.

Male: So, that's 1 percent. So, what we do before giving any e-prescribing incentive, we check to see if an EHR incentive was paid without the case and you wouldn't get the e-prescribing. So, you don't have to worry about it somehow disadvantaging you.

Cheryl McNew: OK. Sounds good and that's what I wanted to know. Thank you.

Christine Estrella: Thanks.

Geanelle Herring: Thank you for the question, Ms. McNew. Holley, next question, please.

Operator: Your next question comes from the line of Kristi Hutchinson.

Kristi Hutchinson: Good afternoon. This is Kristi calling from HCA. Thank you for taking our call.

My question pertains to eRx and we have providers that are receiving the letters stating that they will receive the penalty and the payment adjustment for 2012. My question is if we can prove compliance and reporting, because several of those providers feel like they met the measure and they reported it. Is there are an appeals process in place to dispute the payment adjustment letter?

Christine Estrella: We don't have a formal appeal or any formal review process. That actually, we would have to go to rule making to implement that. However, if you do have issues related to e-prescribing your payment adjustment, you could contact our QualityNet helpdesk, and their phone number and e-mail is listed on the presentation. I don't know if you have it, but the e-mail is qnetsupport@sdps.org. And their phone number is 866-288-8912.

Kristi Hutchinson: So that will just be evaluated on an individual basis?

Christine Estrella: Yes.

Kristi Hutchinson: OK. Thank you so much.

Christine Estrella: OK, thanks.

Geanelle Herring: Thanks, Ms. Hutchinson. Next question, Holley.

Operator: Your next question comes from the line of Julie Sander.

Julie Sander: Hi. I was wondering for those physicians that are new coming on after July 1st, how is it that they avoid the 2013 penalty?

Christine Estrella: Excuse me, what do you mean by new?

Julie Sander: So, I have a handful of physicians who are graduating and starting their first job as a physician in August. How do they avoid the 2013 penalty?

Male: They have to have – they will have to have had at least100 services during the first six months of 2012. Then, your – once you're providing in some situation where they didn't have any services. So, although they – first of all, before they're eligible to get the payment adjustment, they have to be practicing during the first six months. If they did, then they have to submit the e-prescribing, if they weren't practicing with you that they would be subject to.

Julie Sander: OK. So I don't have to fill out the hardship?

Christine Estrella: No. Not if they're – not if they're just graduating and entering your practice in July.

Male: If you know – unless they have at least 100 services that fit in the denominator of the measure that are billed for the time period, July 1st – excuse me, January 1st to June 30th – they won't – they wouldn't be considered for the payment adjustment at all. So, when we . . .

Julie Sander: OK. And then, if I have a new provider that's just changing tax ID numbers, how does that work?

Christine Estrella: Our program actually analyzes providers based on their TIN/NPI combination. So, you know, we would analyze that provider on their agenda JNTI. If they're changing their TIN, we would analyze provider being tracked each to the TIN/NPI as applicable during that reporting period.

Julie Sander: OK. So, if they didn't have any in the first six months under my TIN, it will not be penalized under my TIN?

Christine Estrella: Right, right. It prevents that – you know, if a provider had a prior TIN and, you know, to that – to that definite combination, the payment adjustment would apply to that provider under prior TIN, then the provider would have had to report for that prior TIN.

Male: Yes. That the professionals are no longer working there. So, there is not that applied the penalty against the 2013.

Julie Sander: Great. Thank you so much.

Geanelle Herring: Thank you, Ms. Sander. Holley, next question, please.

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

Susan Stegeman: Hi. I'm just wanting to know if there was a Web site address. We are non-EHR and we want to make sure that we're following the correct documentation guidelines for reporting these services.

Daniel Green: I'm sorry. You said you're not using an EHR?

Susan Stegeman: Not yet. We're setting up the electronic records, but we are not on electronic health records yet or EMR.

Daniel Green: So, if you – so, if you want to report via claims and registries, certainly you can go to our PQRS Web page and it would have the measure specifications as a downloadable information source. It has the list of measures if you want to report via claims, it has the claims page measure specifications.

So, first thing, once you download the information, it would be to select which three measures you want to report and then you'd look up the measure specifications, which would tell you what services are associated with the – with the particular measure and then you would report whether you did or didn't do the quality action on your – on your claim if, again, – if you're using claims.

And, again, you think you had more – there is information on our Web site, but you can actually call our QualityNet helpdesk as well and they can, kind of, help you get started and walk you through the process.

Susan Stegeman: OK. Thank you.

Daniel Green: Thank you.

Geanelle Herring: Thanks, Ms. Stegeman. Holley, do we have any more questions in queue?

Operator: We have three more questions in queue now.

Geanelle Herring: OK. Next question.

Operator: And your next question comes from the line of Shanda Rogers.

Shanda Rogers: Hello, this is Shanda Rogers, and I'm with High Plains Radiation Oncology. And I'm needing some clarification on the eRx programs that qualify such as my understanding is that the Medicare advantage plans do not count. Do – would Railroad Medicare claims count?

Female: Railroad Medicare claims do count.

Shanda Rogers: They do count?

Female: Yes.

Shanda Rogers: Oh, praise the lord. OK, we have one of those and it was going to kick him – it was going to kick him out. And so we were very concerned because he had one and that was going to get him to his 10 for 2011. So, thank you.

Daniel Green: Thank you.

Geanelle Herring: It's great. Thanks, Ms. Rogers. Next question, Holley.

Operator: Your next question comes from the line of Dana Peeterse.

Dana Peeterse: Yes. If you are and have been doing e-prescribing, can you also do the three measurements for the PQRS and get the incentive for both?

Christine Estrella: Yes, you can get the incentive for both and participate in both programs. And we personally would encourage you to participate in both.

Dana Peeterse: OK. Hold on. It was a yes.

Sandy George: OK. Then, can you ask for the second question?

Dana Peeterse: OK. Hold on. Sorry.

I have other people in the room and I picked up the phone to answer the question. They are not getting the answers like I am. And says if so – if it is 50 first.

Sandy George: OK, let me get it.

Dana Peeterse: Hold on.

Sandy George: The second part of the question – my name is Sandy George, I'm sorry. Since the first answer was yes, if they did three measures, if they started doing three

measures right now and by the end of the year they did over 50 percent, would they get the incentive for the three measures?

Daniel Green: Yes, they would.

Sandy George: Yes, they would.

Daniel Green: Another way that they could consider reporting if they – if it applies for them is they could look at one of our measures groups.

Sandy George: Yes.

Daniel Green: The measures group is a cluster of measures around a particular health condition.

Sandy George: OK.

Daniel Green: But there is one even for prevention. So, if they reported on 30 patients . . .

Sandy George: Yes.

Daniel Green: . . . between now and the end of the year, that would be – they'd have to report on all the applicable measures in that measures group for that – for each patient. But if they reported on 30 patients, that would kind of cast them at a maximum number they had to report and they would storm the incentive.

Sandy George: Right. But there – the doctor I was speaking of is a podiatrist.

Daniel Green: OK.

Sandy George: So, the measures that I saw that he could report were, you know, related to the nail care and with diabetes. And so, I don't know that he'd have the preventative report.

Daniel Green: You're right. Typically.

Sandy George: Yes.

Daniel Green: Most podiatrists would be reporting individual measures.

Sandy George: Right.

Daniel Green: As you suggested.

Sandy George: Right. But if we start the report now, I mean – and it's only in March and we reported every one by the end of the year when you did your tabulation it would have been over 50 percent. So, he would get the incentive.

Daniel Green: Right. Again, assuming uneven distribution of patients throughout the year.

Sandy George: Right, right.

Daniel Green: Or as they – here, she sees 20, you know, Medicare patients a month, hypothetically, yes, they would exceed the 50 percent and they would qualify for the incentive.

Sandy George: OK. And the incentive is 1 percent.

Christine Estrella: They got 0.5 percent for.

Daniel Green: OK.

Sandy George: 0.5. Great.

Christine Estrella: It might be one.

Daniel Green: Hang on one second. We're checking.

Sandy George: OK.

Christine Estrella: And we believe that pretty sure that the incentive for this year is 0.5 percent. Sorry, I was getting my years mixed up.

Sandy George: OK.

Christine Estrella: If – but if you do need help in reporting and deciding which measure to find your eligible professional, I would also encourage you to contact the QualityNet helpdesk and they'll help you in getting started.

Sandy George: OK. Thank you so much.

Christine Estrella: No problem. Good bye.

Sandy George: Thank you.

Geanelle Herring: Thank you for the questions.

Sandy George: Yes.

Geanelle Herring: Holley, next question, please.

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

Kevin Burke: Hello, this is Kevin Burke with the Dante Group in Somerset, Kentucky. We provide behavioral health care services. We're going to be implementing our EMR system later this year and going into next year.

We're still working through the process of determining whether or not we can opt out with respect to the e-prescribing program. If we can't opt out, we'll be scrambling to make the current deadline of June 30 of this year. Is there any chance that that deadline will be adjusted?

Christine Estrella: We've set forward the requirements last year if you have that. But, unfortunately, for their – with the respect of reporting the actual measure, that reporting period is set and our reporting period is set.

Kevin Burke: All right. Thank you.

Chrissy: No problem.

Geanelle Herring: Thank you Kevin Burke. Holley, did you have any more questions?

Operator: We have two more questions. And your next question comes from the line of Liz Loving.

Liz Loving: Hi, this is Liz. I have a question about the intent to report. In the past, we've reported F codes on our claims.

But, now, they came out with the G codes with the intent to report on preventative measures. So, would I be reporting that G code followed by all my F codes that relate to that?

Daniel Green: It's – so, just to clear up a little bit the nomenclature here, you mentioned the F codes. The – many of the CPT II codes ended in F. But they are actually called CPT II or quality data codes.

Liz Loving: Yes.

Daniel Green: So, what you would do if you intend to report the preventative measures group is there is a G code that you would fix to the first patient, let's say, in your 30 – of your 30 patients that indicate to us that, hey, I'm going to report the preventative measures group and this is my first patient.

So, you only need to put that particular G code one time on the first claim that you intend to indicate that you're starting that measures group. Now, if you're – if you go to report all the measures in that particular measures group that applied to the – to this particular patient and you did all the quality action, we have created G codes for that.

So, in other words, rather than reporting the preventative measures group, I believe, has roughly nine measure in it. And if possible that online measures tried to apply to one particular patient, so rather than reporting nine of these CPT II codes, if you did all the quality actions that are appropriate for that particular patient, you could report a G code that says I did all of the quality actions applicable to this particular patient. That G code is different than the "I intend to report G code," which is only reported with the first patient one time.

You don't need to report that on every single patient. Just to indicate that, hey, you're starting your measures group reporting for prevention at this time.

Liz Loving: That's why I'm getting confused because like – for instance, if we are reporting for diabetics, the hemoglobin A1c was greater than 7 than less than 6 or whatever, now we're switching gears and going into a G code that's for a whole group of measures.

Daniel Green: Again, it depends. If you're trying to report a measures group, there is a G code that says, "I intend to report to this particular measures group." It could be the prevention measure group that we were talking about before. It could be the diabetes measures groups that contain the hemoglobin A1c measure.

Liz Loving: Yes.

Daniel Green: It really depends on which measures group. If you're intending to report only individual measures, then there is no specific G codes that says, "Hey, I intend to report these three measures." You would just report whatever G code or CPT II codes associated with each of the three measures.

Liz Loving: OK. You see I'm getting burned on the east ride because our computer software stripped away our G code and I'm in the process of trying to appeal that. But like you said, there is no appeal.

You said that a program to appeal. So, I want to make sure that I cover all of my bases with the Gs and the Fs and make sure that I don't get another 1 percent penalty next year because I didn't quite code this right. And I've been decoding courses and there is nothing but confusion out there.

So, I have to turn to you guys for help.

Daniel Green: Oh, we appreciate the question. And, certainly, we're happy to help them – you know what, we realize that the time during this call to, you know, ask questions is a little bit limited.

Liz Loving: Yes.

Daniel Green: Certainly, please feel free to contact QualityNet helpdesk. They can walk you through a particular claim if you're having issues with it. And there are also examples on our Web site on the education information, which actually show

claim – copies of claims and where you're supposed to put each of the – each of the particular codes.

In fact, I believe there is one specifically for the preventative measures group.

Liz Loving: I didn't see that. I only saw the F measures. So, the CPT II codes. I didn't see an example with the group codes.

Daniel Green: OK. So, again, just for clarification, G codes and CPT II codes are both used typically for the same purpose.

Liz Loving: Yes.

Daniel Green: Some G – some measures actually said that CPT II codes or F codes that you're calling them have G codes because the AMA has not created the quality actions CPT II codes for those given measures. There are again – are also G codes to indicate to us that you're reporting a particular measures group. So we judge you based on measures groups as opposed to individual measures.

So, I'm not sure if I'm answering your question completely. But, again, if you do require further assistance, please feel free to contact QualityNet helpdesk.

Christine Estrella: And the QualityNet helpdesk would help you with both of the issues – your PQRS reporting question, as well as any e-prescribing questions you may ask.

Liz Loving: Yes.

Geanelle Herring: Thank you. Holley, next question, please.

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

Jennifer Montgomery: Hi, this is Jennifer Montgomery calling from Beth Israel Continuum Health Care. I have been in conversation this week with the QualityNet helpdesk because I wanted to verify something that had been said previously regarding the 23rd – avoiding the 2013 penalty – where we can submit 10

G8553 codes without any denominator other than the payable with that – with the payable CPT code.

And I wanted to verify that if the provider does that and to get the incentive for 2012, he needs to also do 25 e-prescribes with the denominator and, therefore, 35 total codes for the year.

We're actually kind of in a heavy discussion because the person on the phone at QualityNet keeps telling me, no, they did away with that. You don't have to do any code – any – you can submit all 25 without the denominator and you only have to submit 25 and I keep saying, no. I actually sent her an FAQ recently.

I asked her to please talk to her supervisor because I would like to verify it's 35 and/or 25. I'm kind of confused on that. Could you speak to that?

Daniel Green: I could. First of all, would you like a job with our helpdesk? Because you're actually correct.

So, let me just really quickly go over the way you said that you're going to report this. So, if you're trying to avoid the 2013 penalty, you are correct. You would need 10 e-prescribing events, they need to be associated with a billable service – so, a billable CPT code – but they do not need to be one of the codes that specifically appear in the denominator of the measure. To earn the incentive for 2012, you have to do 25 e-prescribing events.

That's the G8553 code that you were talking about before. And those e-prescribing events would have to be associated with a code that appears in the denominator of the measure. Now, if it turns out that in your first 10, let's say – let's say five of them are in the denominator of the measure and you're trying to – and the other five are not.

So, OK. So you do that in the first six months and you avoid the payment adjustment for 2013. The first – the five of those that were associated with the denominator-eligible code would count as five of your 25 necessary to earn the incentive.

So you really only need to do 20 more. But if none of the 10 are associated with the code in the denominator and you were trying to earn an incentive in 2012, you would have to do a full 25 more e-prescribing events and report them and they have to be for denominator – for services in the denominator of the measure.

Jennifer Montgomery: Perfect. Is there somewhere in writing that I could get that, so I could share that with this person?

Daniel Green: We'll take care of that.

Jennifer Montgomery: OK. I thank you very much.

Christine Estrella: Thank you.

Geanelle Herring: Thank you, Ms. Montgomery. Holley, next question, please.

Operator: At this time, there are no further questions.

Geanelle Herring: All right. Well, if you think of a question and you didn't – and you're not successful in bringing it today, you can contact our QualityNet helpdesk, and that number is 866-288-8912, and they're available 7 AM to 7 PM Central Standard Time, Monday to Friday, or you can send an e-mail through qnetsupport at S as in Sam, D as in dog, P as in Paul, S as in Sam .org.

Please note that while we were not able to address every questions that were sent to us prior to today's call, we will review them to help us develop Frequently Asked Questions, educational products, and future messaging on those questions.

If you joined us late, you may have missed the announcement that all of the announcements that were given out prior on today's call were sent out in the listserv message just before you joined us. On slide 31, you will find information and a URL to evaluate your experience with today's National Provider Call. Evaluations are anonymous and strictly confidential.

I will also point to you that if you – as a registrant for today's call, you will receive a reminder e-mail from CMS National Provider Call's resource box within two business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. We appreciate your feedback.

I'd like to thank everyone for participating today. An audio recording and written transcript will be posted to the Physician Quality Reporting System Webpage on CMS Web site under the CMS Sponsored Calls tab in approximately two weeks. Again, my name is Geanelle Herring, and it's been a pleasure serving as your moderator today.

I'd like to thank Drs. Wright and Green and all of the SMEs assembled here today for their participation. Have a great day, everyone.

Operator: Thank you for participating in today's conference. You may now disconnect. Speakers, please hold the line.

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