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Centers for Medicare & Medicaid Services
How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment
National Provider Call
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time, I'd like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Charlie Eleftheriou. Thank you, sir. You may begin.

Announcements and Introduction

Charlie Eleftheriou: Thank you, this is Charlie Eleftheriou from the Provider Communications Group here at CMS, and I'll serve as your moderator today. I'd like to welcome everyone to this Physician Quality Reporting System and Electronic Prescribing Incentive Program National Provider Call on how to avoid 2014 eRx and 2015 PQRS payment adjustments. Today's National Provider Call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers.

The presentation will be followed by a question-and-answer session giving participants an opportunity to provide input and ask questions. Before we get started, there are a few items I'd like to cover. There is a slide presentation for this session. A link to this presentation and today's announcements were e-mailed to all registrants a little bit after 12:00 today. 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 Calls Resource Box. Also, the presentation can be found by visiting www.cms.gov/npc, as in National Provider Call. That's cms.gov/npc. Then click the "National Provider Calls and Events" link on the left-side navigation panel and find today's call by date on the list.

Next, a quick reminder that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Physician Quality Reporting System and National Provider Calls Web pages on the CMS Web site. Also, we'd like to thank those of you who submitted questions when you registered. Your questions were shared with the speakers to help prepare for today's call. Lastly, please note that all pertinent resources and contact information related to today's call are available on slides 31 through 33 of today's presentation.

With all that said, I'd like to turn the call over now to Molly MacHarris. Molly?

Presentation

eRx Incentive Program: Background and Payment Adjustment Overview

Molly MacHarris: Thank you, Charlie. I will go ahead and get started on the presentation beginning on slide 3. Again, as Charlie indicated earlier, today's presentation will cover the e-prescribing payment adjustment and the PQRS payment adjustment. So, going ahead and getting started, moving on slide 4, the e-Prescribing Incentive Program background and payment adjustment overview, and then on to slide 5, the background.

E-prescribing was first established in 2009, and the E-Prescribing Incentive Program seeks to encourage the use of electronic prescribing by providing incentives and payment adjustments based on whether eligible professionals or group practices participating in the E-Prescribing Group Practice Reporting Option meet the criteria for being successful electronic prescribers.

The e-prescribing incentive amounts: As you can tell on this slide here, they have changed over the years, starting with 2 percent in 2009 and 2010, 1 percent for 2011 and 2012, and then the last reporting period, which we are in right now, the 2013 calendar year, there's a half-a percent incentive payment for eligible professionals in group practices.

For the e-prescribing payment adjustment: It began in 2012 with a 1 percent reduction for calendar year 2013. E-prescribers who are not successful will receive a one-and-a-half percent reduction in charges. And the last payment adjustment will take effect in calendar year 2014, which will reduce eligible professionals' in group practice—group practices charges by 2 percent.

The 2012 and 2013 Physician Fee Schedule Final Rule sets forth the requirements for the 2012 and 2013 E-Prescribing Incentive Program incentive payments and for the 2013 and 2014 e-prescribing payment adjustments. Just as a reminder, there are no E-Prescribing Incentive Program incentive payments scheduled past program year 2013, and the e-prescribing payment adjustments, the last year for that is 2014. So this is the last performance period for the E-Prescribing Incentive Program and for the e-prescribing incentive payment adjustment.

Moving on to slide 6, the reporting periods available: The 12-month period only applies to the 2013 e-prescribing incentive payment. Again, this is the last opportunity to earn that half-percent incentive. It must generate e-prescribing events and report the required number of denominator-eligible visits, and the methods that are available are claims, registry, or qualified EHR.

All claims must be processed into the National Claims History File by February 28th, 2014, for inclusion in our analysis. The 6-month reporting period of January 1st through June 30th, 2013, only applies for the 2014 e-prescribing payment adjustment.

Again, this is the last reporting period available to avoid a 2014 e-prescribing payment adjustment, so CMS strongly encourages all eligible professionals and group practices to report their required number of instances during this 6-month timeframe. Again, those instances can be reported on any payable Medicare Part B PFS service. The only method that folks can participate in is via claims, and all claims must be processed into the National Claims History by July 26th, 2013.

Moving on to slide 7: The analysis occurs in two different ways. For individual eligible professionals, we analyze providers at the unique Tax Identification Number/National Provider Identifier, or TIN/NPI, combination. The e-prescribing payment adjustment may be applied to each unsuccessful TIN/NPI, and as another reminder, the analysis is based on the individual/rendering NPI, not the group NPI.

For eRx GPROs, they will be analyzed at the TIN level, under the TIN submitted at the time of final self-nomination. If an e-prescribing GPRO is unsuccessful at avoiding a payment adjustment, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment. If an organization or eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis.

Moving on to slide 8 for more on the e-prescribing payment adjustment: Individual EPs who meet all of the following criteria may be subject to the 2014 e-prescribing payment adjustment. : (1) If you have more than 10 percent of an individual EP's allowed charges for the 2013 e-prescribing 6-month reporting period—again, that's that first 6 months from January 1st to June 30th, 2013—comprised of codes in the denominator of the 2012 e-prescribing measure.

(2) You would have to meet the taxonomy criteria: again, the doctor of medicine, doctor of osteopathy, and those listed on the slide here. And we look at that based on your NPPES status as your primary specialty taxonomy criteria.

And lastly, (3) we will check to see if you have more than 100 cases containing an encounter code in the measure's denominator during the 2013 e-prescribing 6-month reporting period. And if an EP does not meet one of the above criteria, they will be automatically exempt from the 2014 e-prescribing payment adjustment.

Moving on to slide 9: E-prescribing GPROs who meet the following criteria may be subject to the 2014 e-prescribing payment adjustment, and that is that they would have to have more than 10 percent of their allowed charges for the 2013 6-month reporting period comprised of codes in the denominator of the 2013 e-prescribing measure.

Moving on to slide 10: More information on the payment adjustment, the remittance advice, the indicator "LE" for all Medicare Part B services rendered from January 1st to December 31st, 2014, and the Claim Adjustment Remittance Code and the Remittance Advice Remark Code—those codes are CARC 237 and RARC N545.

So this is how, as a provider, you can identify whether or not you are subject to the 2014 e-prescribing payment adjustment, and again, that would take us back on claims for dates of service January 1st through December 31st, 2014.

If CMS—if we determine that the payment adjustment was applied in error, the claim will be re-processed to return the 2 percent, and the Remittance Advice for the re-processed claim will include the codes CARC 237 and RARC N546.

eRx Incentive Program: How To Avoid the 2014 Payment Adjustment

Moving on to slides 11 and 12 of How To Avoid the 2014 E-Prescribing Payment Adjustment: As slide 12 indicates, individual EPs and e-prescribing GPROs can avoid the 2014 e-prescribing payment adjustment through one of the following steps.

One, if you were a successful electronic prescriber for the 2012 e-prescribing 12-month reporting period, or if you were a successful electronic prescriber for the 2013 e-prescribing 6-month reporting period—and, again, the dates for the 12-month period are January 1st, 2012, through December 31st, 2012—so essentially if you were incentive-eligible for the 2012 e-prescribing incentive.

The second opportunity, and the last opportunity to actually report for the e-prescribing program for purposes of the payment adjustment, is the 6-month reporting period, which, again, is from January 1st through June 30th, 2013.

Another way to avoid the 2014 payment adjustment is to request a 2014 e-prescribing hardship exemption if one applies to you. The next way is to achieve Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the 12-month or 6-month e-prescribing reporting period, or demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by registering and providing your EHR certification ID by June 30, 2013, and adopting certified EHR technology.

Slide 13 provides a breakout of the ways you can report. So, again, for the 2012 e-prescribing reporting period, the 12-month period, you would have had to have reported the e-prescribing measure's numerator on at least 25 instances for the associated denominator code, and that can be reported through claims, registry, or EHR. For the 6-month period, only 10 instances are required, and that can only be reported through claims. And again, that is on any payable Medicare PFS service.

Slide 14 provides a breakout of the e-prescribing GPRO methods of avoiding the 2014 payment adjustment. For the 12-month period, there were two sizes of GPROs available, the 25 to 99, and the 100-plus. And for the 25 to 99 group, they would have had to have reported the e-prescribing measure 625 times. For the 100-plus group, it would be 2,500 times.

And then for the GPROs who have self-nominated for purposes of the 2013 incentive payment and for purposes of avoiding the 2014 e-prescribing payment adjustment, the tiers available are 2 to 24, where you would have to report the e-prescribing measure 75 times; 25 to 99, you would have to report the e-prescribing measures 625 times; and the 100 and plus group, you would have to report the e-prescribing measure 2,500 times.

And remember, for the 6-month period, you can report that e-prescribing numerator code on any payable Physician Fee Schedule service. It doesn't have to be associated with the measures included in—with the codes included in the e-prescribing measure's denominator.

Moving on to slide 15, the hardship exemptions we have available: So we have those that we finalized in previous rules:

- Unable to electronically prescribe due to local, State, or Federal law or regulation.
- That you have or will prescribe fewer than 100 prescriptions during the 6-month reporting period.
- That you practice in a rural area without sufficient high-speed Internet access, and the G8642 indicates that you can report that hardship via claims.
- The practice in an area without sufficient available pharmacies for electronic prescribing (again, the G8643 indicates you can report that hardship via claims).
- If you do not have prescribing privileges during the 6-month reporting period (again, the G8644 indicates you can report that via claims).

- And then the two Meaningful Use hardships that EPs or group practices who achieve Meaningful Use during certain e-prescribing payment adjustment reporting periods, and EPs or group practices who demonstrate the intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology. And for these two hardships, no additional action is required on part of the EP or group beyond ensuring that you successfully attest and register for the EHR Incentive Program. Those hardships will automatically be processed by CMS.

Slide 16: Again, for the 2014 e-prescribing hardship exemptions and lack of prescribing privileges, they must be submitted on or before June 30th, 2013. We will send messages out that will announce the opening of the Communication Support page for 2014 e-prescribing hardship exemption requests.

And again, those hardship exemptions that have an associated G-code can be reported on any payable Medicare PFS claim with dates of service of January 1st through—this should be June 30th, 2013. We'll correct the slide on that. And then for the 2013 e-prescribing GPROs, they must indicate hardship exemptions during the self-nomination period or submit an exemption request via the Communication Support page.

Slide 17 outlines the process of submitting the hardship exemption request. Again, at this point, it is not open yet for purposes of the 2014 e-prescribing payment adjustment. When we open the Communication Support page for purposes of requesting a hardship for the 2014 e-prescribing payment adjustment we will provide announcements either through the National Provider Call or through listserv mechanisms. So please stay tuned for more information on that.

Physician Quality Reporting System: Background and Payment Adjustment Overview

OK, moving on to slide 18 and 19 for information on PQRS and the upcoming payment adjustment. So slide 19—just some brief background on the Physician Quality Reporting System. The program was established in 2007, and it is a Medicare Part B reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of Physician Fee Schedule quality information by eligible professionals and group practices.

The incentive amounts: As you can tell on the slide, they have changed over the years. We do continue to have a half-a-percent incentive payment for program year 2013 and for next year, for program year 2014. The PQRS payment adjustment amounts begin in 2015, and it will be a one-and-a-half percent reduction for years 2015. For 2016 and beyond, it will be a 2-percent reduction if you are not a satisfactory participant in the Physician Quality Reporting System. Again, these requirements are included in the 2013 Physician Fee Schedule Final Rule. And just as a reminder, no PQRS incentive payments are scheduled past program year 2014.

Moving on to slide 20, those who are eligible to receive the 2015 PQRS payment adjustment: It's our typical list of eligible professionals that include your physicians, your practitioners, and therapists.

Slide 21: The analysis. So, we perform the analysis at two levels: one for individual eligible professionals and for PQRS group practices.

For the individual eligible professionals, that analysis occurs at the unique TIN/NPI combination. And again, as a reminder, we do look for the individual/rendering NPI, not the group NPI in that analysis. And if an eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis. In the PQRS system, we would view a new TIN as a new provider.

And again, at the group level, we analyze that information at the TIN that is submitted at the time of self-nomination, or what will be included in the upcoming registration period, which we will be providing more information on in future calls and future listservs.

And again, if the group is unsuccessful at avoiding the payment adjustment, all of the NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment.

Slide 22, the payment adjustment application: So for the 2015 PQRS payment adjustment, the reporting period is calendar year 2013. For the 2016 PQRS payment adjustment, the reporting period is calendar year 2014. And as I indicated previously, the adjustment amount for the 2015 payment adjustment is a one-and-a-half percent reduction, and a 2-percent reduction in 2016.

And an important note, that if you are a group practice consisting of 100 or more eligible professionals, beginning with the 2013 program year, your physicians may also be subject to the 2015 Value-Based Payment Modifier, and we strongly encourage folks to take a look at the CMS value-modifier Web site for additional information.

Physician Quality Reporting System: How To Avoid the 2015 Payment Adjustment

OK, moving on to slides 23 and 24: So how to avoid the 2015 PQRS payment adjustment. Slide 24 indicates that for individual eligible professionals we have three main ways you can avoid the payment adjustment.

One is to meet the criteria for satisfactory reporting for the 2013 PQRS incentive payment. So that would be your typical criteria of three measures at an 80 percent reporting rate, et cetera, et cetera.

An additional way to avoid the payment adjustment is to report one valid measure or one valid measure group. And the last way is to elect to be analyzed under the administrative claims-based reporting mechanism. And we will be opening up this registration period to elect the administrative claims-based reporting mechanism in the summer of this year. So again, please stay tuned for additional information that will be forthcoming in the next few months, giving specific details on how eligible professionals can elect the administrative claims-based reporting mechanism.

Slide 25 for the group practices: So again, similar criteria. One: You would need to meet the criteria for satisfactory reporting for the 2013 PQRS incentive payment under the Group Practice Reporting Option. So if you are a GPRO reporter and you lack the Web interface reporting mechanism, you would need to fill out the Web interface for the required number of beneficiaries up to the sample size.

The second option is to report one valid measure. And just to note the sub-bullet here, that is not accurate, and we will be updating the posted presentation after the call with revised information. And then the last option is to elect to be analyzed under the administrative claims-based reporting mechanism, and again, we will be providing additional details on how to select this reporting option later on this year.

And just another note, that the administrative claims-based reporting mechanism is not available to ACO GPROs. And if you are participating in PQRS through another CMS program, such as the Medicare Shared Savings Program, please check the program's requirements for information on how to simultaneously report under PQRS and the respective program.

Moving on to slide 26, we have a decision tree to guide providers on how to avoid the PQRS payment adjustment. And then on slides 27, 28, and 29, we have additional information on the reporting options available for satisfactory reporting for individual eligible professionals and group practices.

Slides 30, 31, 32, and 33 provide our basic information on additional resources and where to call for help. Just one important thing to note: Slide 33 does provide the information for the QualityNet Help Desk. They are available Monday through Friday from 7:00 a.m. to 7:00 p.m. Central Standard Time, and they can be reached either via phone at 866-288-8912, or via e-mail, qnetsupport@sdps.org.

At this point, I will turn the call back over to Charlie.

Keypad Polling

Charlie Eleftheriou: Thanks a lot, Molly. At this time, before we move into our question-and-answer session, I'd like to conduct keypad polling in order to obtain an estimate of the number of participants in attendance, to better document how many members we have of the provider community that are receiving this valuable information. We're ready to start polling now.

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. 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 between 2 and 8. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, please enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Charlie Eleftheriou: While we were holding for keypad polling, I'd like to take this time to remind everyone that this call is being recorded and transcribed. So if you're going to be calling in for question-and-answers, please, before asking your question, state your name and the name

of your organization. And in an effort to get to as many of your questions as possible, we ask that you limit your questions to one at a time. If you do have more than one question, please feel free to press star 1 after asking your first question to get back into the queue, and we'll address additional questions as time permits. Holley, we're ready to take our first question when keypad polling is finished.

Question-and-Answer Session

Operator: And that does conclude the polling session of today's call. As Charlie stated, we'll now move into the Q&A session for the call. To ask a question, please press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

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

And your first question comes from the line of Amanda Conley.

Amanda Conley: Yes. This is Amanda with Family Practice Center. I have a question regarding claims-based reporting for the PQRS. We are part of an ACO. Do we still need to do claims-based reporting, or does our ACO handle that for us? We're unclear on that.

Molly MacHarris: Sure. This is Molly. And, no, you will not need to do claims-based reporting. You're reporting through the ACO. Your reporting of the quality metrics through the group practice Web interface will apply for purposes of the PQRS payment adjustment.

Amanda Conley: OK. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Terry Parish.

Terry Parish: Hi. I'm Terry Parish with Colorado Retina Associates. I had a question. If you have attested to Phase 1 for Meaningful Use, do you still have to report the ERS codes claim-based?

Molly MacHarris: Sure. This is Molly again. And, yes, you will still need to—well, let me ask you an additional question. Are you asking in context of the e-prescribing payment adjustment?

Terry Parish: Yes.

Molly MacHarris: OK. So for purposes of the e-prescribing payment adjustment, for the 2014 e-prescribing payment adjustment, did you achieve Meaningful Use during one of the periods I referenced in the presentation? If you look at slide…

Terry Parish: I believe we have. Now, is "attested to" and "achieving" the same thing? I'm not personally responsible for our Meaningful Use reporting.

Molly MacHarris: Yes. So if you achieved Meaningful Use—meaning you successfully registered and attested through either the Medicare or Medicaid EHR Incentive Program during either the 12-month timeframe of January 1st, 2012, or—through December 31st, 2012—or the 6-month timeframe of January 1st, 2013, through June 30th, 2013, you will automatically be exempt for the 2014 e-prescribing payment adjustment.

Terry Parish: So we would not need to individually report that?

Molly MacHarris: No. You would not need to individually report it to avoid the e-prescribing payment adjustment.

Terry Parish: OK.

Molly MacHarris: But just one additional thing to note, you'll just want to make sure that the billing identifiers you've used under the Meaningful Use EHR Incentive Program match what you bill to on your CMS 1500 claims forms. Because on the e-prescribing PQRS side, we look at the distinct TIN, the Tax Identification Number, and the individual/rendering NPI that you bill or your provider bills under to assess the e-prescribing incentive payment and the e-prescribing payment adjustment.

So you'll just want to make sure those were the same identifiers you used when you attested for the Meaningful Use Program.

Terry Parish: OK. OK, great.

Molly MacHarris: Thank you.

Terry Parish: Thank you.

Operator: Your next question comes from the line of Antossyan Levon.

Levon Antossyan: Yes. I am Levon Antossyan), and I practice in Los Angeles, California. I am already seeing my N545 deductions from the bills I am getting paid, and I achieved the Meaningful Use in 2012. Meantime, I'm participant in ACO. Is it possible that this ACO have to do something with it, or why I'm seeing that my friends already adjusted? Thank you.

Molly MacHarris: Sure. So this is Molly again. When did you achieve Meaningful Use in 2012?

Levon Antossyan: Somewhere—it was October or something like that. I don't have exact date, but at the end of the year.

Molly MacHarris: OK.

Levon Antossyan: 2012.

Molly MacHarris: OK. So what we have for the 2013 e-prescribing payment adjustment, we did finalize in last year's rule the two additional Meaningful Use hardships whereby, if you achieve Meaningful Use during distinct timeframes, you would no longer be assessed the e-prescribing payment adjustment. I don't have the timeframes, unfortunately, in front of me for purposes of the 2013 e-prescribing payment adjustment, when you would've had to have achieved Meaningful Use. So what we can do is, if you contact the QualityNet Help Desk—and again, their information is available on slide 33—they can open up a Help Desk ticket, and they can check with CMS here, and they can determine whether or not you will receive the Meaningful Use e-prescribing hardship exemption.

Levon Antossyan: OK. So ACO has nothing to do with this?

Molly MacHarris: No. So for the ACO program, the relationship is with the PQRS program. And while PQRS and e-prescribing, they are very similar in nature, they are separate and distinct programs, and participation in one does not carry over for participation in the other. So your participation in the ACO program should have no bearing on your participation in the e-prescribing program.

Levon Antossyan: OK. Is that—slide 13 has the information where to call?

Molly MacHarris: Sure. It's slide 33. The phone number is 866-288-8912, and you can reference that this was based off of guidance from CMS on today's National Provider Call, and they will look into this for you.

Levon Antossyan: Thank you very much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Michelle Bryant.

Michelle Bryant: Hello?

Operator: Yes. Go ahead. Your line is open.

Michelle Bryant: Hi. This is Michelle Bryant. I'm with the Wayne State University Physician Group, which is a group the size of—greater than 600.

My question is basically related to some challenges I've had over the last few months. I have been trying to get a definitive answer from CMS. I have communicated through e-mail as well as through phone without successfully getting anything in writing.

The reason being is that our group is very large. It's a multi-specialty specialty group. We participate in an ACO, so therefore, our TIN number is associated with an ACO. A very small percentage of our physicians, the primary care physicians, are participating within the ACO. The remainder of our group, which is more than 500 multi-specialists, are not.

My question to CMS, where I have not gotten any answer, is, what does that mean for the remainder of my group? I'm told that for 2012—and this was recently, I was told this over the phone; I have not seen anything in writing as of yet—but for 2012, my whole group will receive credit for PQRS based on our ACO submission. Those 19 physicians will represent more than 600 physicians for 2012. However, no decision has been made as of yet for 2013. And this is because we are a large multi-specialty group, and I don't believe there was consideration to how we would be impacted from a value modifier perspective and/or for submission for the majority of the group versus just a small fragment of the group.

Is there anyone there that can help me get my questions answered that I've submitted multiple times to CMS now?

Molly MacHarris: Sure. So, just a couple of questions: Are you participating in the Medicare Shared Savings Program ACO or the Pioneer ACO Program?

Michelle Bryant: That's a very good question. For 2012, we were only a small—I think 19 physicians, to be exact, participated in a Pioneer ACO. However, for 2013 some of our specialists have requested to participate in an MSSP ACO, but this is new.

In the meantime, we still have the larger portion of our physicians in neither, but our TIN number is in both. I've been told by CMS to date that they, at this time—and I was trying to get answers before January 31st because that was the first deadline for the Value-Based Modifier—at this time, there's no definitive answer in regards to the Value-Based Modifier, whether, you know, they're going to give us credit for the whole group as one, considering the small group of physicians that's participating in the ACOs, or they're going to have us to submit individual data for the remainder of our physicians.

These are the question marks that I have not gotten an answer. I've been told as late of January 31st–30th, to be exact, I think—that they're still trying to decide what to do with us.

Molly MacHarris: Right. OK. We understand your concern and I apologize. Unfortunately, we don't have any ACO subject-matter experts here with us in the room. And it sounds like your case is especially nuanced since for 1 year [you] participated as a pioneer ACO. It sounds like some of your providers wish to participate in the Medicare Shared Savings Program ACO program for 2013.

Michelle Bryant: Right.

Molly MacHarris: I can tell you that the January 31st deadline for self-nomination as a group practice was not the final deadline.

Michelle Bryant: Right. There's a second one.

Molly MacHarris: So there will be an additional time period that is upcoming in the summer, where, if it is—after, you know, after CMS, we work through your particular case, that you would need to participate in the PQRS program and/or the value modifier program so you don't

receive a downward payment adjustment on either side. You would still have time to register. Unfortunately, though, since we don't have the subject-matter experts on the ACO program in the room, I'll have to point you to their Web site, and their information is available on slide 31. I do apologize, but…

Michelle Bryant: Yes, that—I thank you, Molly, but that doesn't help me. I've been utilizing the Web site, and I actually have a point of contact that I sent e-mails directly to without getting timely response. It's a challenge with the complexity of these programs, not getting timely response from the—from the CMS when you're trying to be compliant.

Molly MacHarris: Right. Right. And—and we understand. The only other option I could suggest is you could open a Help Desk ticket with the QualityNet Help Desk. They don't particularly service ACO-related items, but they can provide information on the correct ACO folks who can answer your question. Again, you know, we do apologize. Over here, we just don't have the subject-matter experts to answer your question and give you the right information.

Michelle Bryant: Thank you, Molly.

Molly MacHarris: Thank you.

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

Mary Smith: Hi. This is Mary Smith from Pulmonary and Sleep Physicians of South Jersey. And my question is, we have a physician that—really she's—her specialty doesn't fit any of the quality measures for PQRI. So if—are you saying if she just—if we find one on there, we only have to report one on 50 percent of her claims?

Molly MacHarris: Oh, sure. This is Molly again. So for purposes of the PQRS payment adjustment, they would need to report at least one measure one time on a valid—so it has to be one valid measure. And what we mean by "valid" is that it would have to have a denominator-eligible patient—so, the correct E&M codes, the correct diagnosis codes—and you would have to apply a correct numerator code.

However, with that being said, we do strongly encourage all providers to report, at the incentive eligibility criteria threshold, the three measures at either 50 percent or 80 percent, because, as we indicated in last year's rule and through additional communication, we view this low-threshold reporting really a preliminary option to encourage more participation in the PQRS program.

Mary Smith: Yes. And I hear what you're saying, and we would love to be able to do that; that's what we do for our other physicians. But there is absolutely nothing else on there that—that goes with what her specialty is. That's why we were having trouble finding three. I don't—I hope we can find one.

Kim Schwartz: If we could ask you, just out of curiosity, what is her specialty?

Mary Smith: Sleep—sleep disorders.

Kim Schwartz: Thank you.

Molly MacHarris: Another suggestion that we have is, again, you can contact the QualityNet Help Desk. Their information's on slide 33. And the Help Desk will actually sit with you on the phone, and they will help you determine if there are any appropriate measures that this eligible professional can report on. I don't, off the top of my head, know if there are any measures. But the Help Desk will work with you to ensure that, if there is a measure that the provider can report on, they will find it.

Mary Smith: OK. Alright. Thank you so much.

Molly MacHarris: Thank you.

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

Debbie Darby: Hi. This is Debbie Darby from Bone and Joint Clinic in Baton Rouge, Louisiana. I have a question about the hardship exemption. I'm going to have to file "no prescribing privileges" for three EPs, but does the G8644 code need to be on every claim submitted by those EPs in that reporting period?

Molly MacHarris: You only need to submit the code at least one time, and it has to be on a payable Medicare Part B charge, but it would have to be reported for each provider that you are seeking the exemption for. So for all three of those providers you would have to report the—the G8644. You said they don't have prescribing privileges. Is that correct?

Debbie Darby: Right. In Louisiana, PAs can't have them for 1 year.

Molly MacHarris: OK. So you would just want to report the G8644 for each TIN/NPI. Again, make sure it's the individual/rendering NPI's information. And as long as you submit it once on a payable Part B charge, they should be good.

Debbie Darby: Alright. Thank you.

Molly MacHarris: Thank you.

Operator: And your next question comes from the line of Burhan Ahmed.

Burhan Ahmed: Yes. Hi. My name is Burhan Ahmed. I'm a billing service. I have multiple providers for multiple specialties. My question is that, who are the ACOs?

Molly MacHarris: Sure. This is Molly again. The ACOs refer to the Accountable Care Organizations. And it is a quality reporting program that is offered by CMS where, if these practices sign up to be an ACO, they can receive shared savings. There's two options available: the Medicare Shared Savings Program and the Pioneer ACOs. Again, as we mentioned earlier on this call, we don't, unfortunately, have any subject-matter experts here in the room on the ACO

program. But if you go to slide 32, the third bullet down provides a link to the Medicare Shared Savings Program Web site, and you can look for more information on the ACO program there.

Burhan Ahmed: OK. So you mean to say that any provider, either as an individual or group, he has to choose one or the other, either as a shared program or as a value-based?

Molly MacHarris: I'm—I'm sorry. I'm not sure that I'm understanding your question.

Burhan Ahmed: OK. What I'm trying to—you know, the—the question is that you—you know, either the—the provider, the physician is an individual or a—in a group. He has to report these PQRS measures, but he can choose to be in the ACOs, or he can choose without ACOs. Is that correct?

Molly MacHarris: No. That's not completely accurate. So a provider—you're correct, they can choose to participate in the PQRS program through a variety of ways. They can choose to do so either as an individual EP or as a group practice. But if they choose to elect the Group Practice Reporting Option, they do not have to be an ACO. They could just be a PQRS group practice. And, by participating in that option, they may be subject to the physician Value-Based Modifier if they are in a group practice with one TIN with 100 or more NPIs.

And, again, those group practices will need to either have self-nominated by January 31st, or they will need to register in the upcoming summer timeframe, which I mentioned a couple of times earlier on the call that we will be providing additional information on. But a provider, they don't necessarily have to participate in the ACO option, but it is an option available to them if their organization wants to try to receive those shared savings.

Burhan Ahmed: OK, alright, thank you very much.

Molly MacHarris: Thank you.

Operator : And your next question comes from the line of Julie Nichols.

Julie Nichols: Hi, this is Julie Nichols calling from Arnot Medical Service in Elmira, New York. My question is in regards to the GPRO Web interface. I too have called in and had some e-mail conversations with members of the customer service Help Desk and have not gotten a clear answer on this yet as well. It says that you get a prepopulated sample. My group size is over 100. We would get a group sample of 411 Medicare beneficiaries, and we would have to submit information based on the 22 measures for that group.

My question is, what is the performance rate that is considered acceptable reporting? For an example, if you have 411 beneficiaries, and one of those 411 does not get their flu vaccine, does that mean then you will receive the penalty? I'm not quite how the performance rate—and what is considered satisfactory reporting.

Molly MacHarris: Sure, so for PQRS specifically we will look at your reporting on the 411 patients. So again, we have a certain set of criteria where we would want to make sure that the

patients are reported on. I believe there is a certain number of skips that are allowed. I apologize again, I don't have the exact information in front of me, but I know there is the patient sample, and there are a certain number of skips that are allowed.

So for PQRS purposes we would look to ensure that the reporting of the patients for the required measures occurs. For some of the other programs, such as the Value-Based Modifier, they will be looking at the quality data compared to cost, but, unfortunately, I can't speak to that.

(Pam Cheetham): Which program are you asking the question about?

Julie Nichols: The GPRO Web interface.

Molly MacHarris: OK, so the information I gave you specific to PQRS—again, that's correct, that you would just need to report on the measures up to the patient sample.

Julie Nichols: Right, but how do we know what is considered satisfactory reporting? I mean, we are trying to make decisions based on: Do we want to do the GPRO Web interface? Do we want to do this CMS administrative claims? And without accurate information as to know, you know, what we are going to be based on as far as whether we are going to get penalized or not, if that information is not available to us, we are not able to make an educated decision.

Molly MacHarris: Sure, so on slide 29, it provides an outline of the different GPRO options available, and depending upon your group size. What group size are you?

Julie Nichols: We are over 100.

Molly MacHarris: OK, so you would have two options available to earn the incentive, and the first would be reporting through registries, and you would need to report at least three measures for 80 percent of the total group practice's Medicare Part B charges.

The second is through the Web interface, and again, you would need to report on all measures included in the Web interface, and populate the data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group sample. There is an oversample of 534 for each module or preventive care measure.

Julie Nichols: What does that mean? What does that mean, there's an oversample of 534? Does that mean you give us 534 patients, and we have to report accurately on 411?

Pam Cheetham: Yes. Yes.

Julie Nichols: That's what that means?

Pam Cheetham: Yes.

Molly MacHarris: Yes.

Julie Nichols: OK. So, if we did 4—and I'm just—because I just want to be sure I understand—so you prepopulate our sample with 534; 411 of those must have every single one of the 22 measures in order for it to be considered satisfactory reporting? Or is there percentages?

Pam Cheetham: No. It's really based on you providing the information that's asked for in the tool. But you're not going to be graded if you don't have enough patients with high blood pressure. You're not going to get a demerit for that.

Julie Nichols: I guess I'm still not sure. I still don't understand how we get assessed on that. What—how would I know—if I'm entering data in—on these patients, how am I going to know what is considered satisfactory reporting? We're trying to gear our education for our physicians so they all understand, and I can't get them to understand if I don't understand.

So, those 22 measures that we have to document on for those 411 patients—so how do I know when—what is considered satisfactory reporting for that 411? Do you have to have all 22 measures for all 411 patients? Can you have 80 percent with the flu shot? Can you have 40 percent with the pneumonia? I mean, it just—there's no—I don't know what the performance rate that you're looking for is.

Courtney Rose: Hi. This is the PMBR team. Within the Web interface you will be notified by—like a green check mark, for example, when you've completed each patient within the module. And you will be—I mean, once your module then is complete, you'll be notified within the Web interface.

Julie Nichols: But if I was going to turn around and explain this to our physicians, and they say, what is the performance rate that we're being subject to? I don't have that answer. So, is it a percentage that I'm allowed, or is it 100 percent of all the measures for that group, or perhaps I'm not making my question clear. I don't know what the performance rate is that we're going to be measured against.

And I certainly don't want to wait until the beginning of the following year when I start entering data in if I don't know what we're being measured against. We have this whole year to be working on that. So, is there a performance rate? You know how, like with the PQRS, if you're doing individual, you have to submit, you know, 25 patient charts. Or you have to submit 80 percent of your, documentation. Those kinds of—those are performance metrics. Well, this 411 chart is not telling me what the performance metric is that you're looking for.

Molly MacHarris: Sure.

Courtney Rose: In order to complete the Web interface—sorry, Molly.

Molly MacHarris: No, go ahead, Courtney.

Courtney Rose: Yes. So, in order to complete the Web interface, what we will do is we will pre-fill each module within the Web interface and patient care measure with up to—well, you know, hopefully we'll be able to pull enough beneficiaries so that we have that 534 to prepopulate. But

there may be an instance where your heart failure module only has 230 beneficiaries, so then you would need to report on—if we have enough to fill that 534, you would need to report on 411. And if, let's say, you know, we don't have enough to get you to that 411, then you'd do 100 percent. So, like, 320 or, you know, 215, whatever that may be.

Julie Nichols: OK. So, if I had 215, for example, then all 215 have to have one of every single measure of the 22 measures?

Courtney Rose: No. So the way that the module—or the way that the Web interface is prepopulated is you will get 411 patients per module and 411 patients for each of the patient care measures, and that consists of both the care coordination patient safety measures, which there are two of, as well as the preventive care measures, which there are eight of those.

Julie Nichols: OK. So as I'm prepopulating the 411 charts, for an example, and 20 percent of my patients refused their flu shots, or did not get their flu shots, are we good? Are we not good? What are we measured on?

Courtney Rose: Right. So within the Web interface, you'll have the option to tell us, "Hey, they refused their flu shot. They didn't get a flu shot." You'll tell us that, you report that, and then that will be counted complete for reporting.

Julie Nichols: What if they don't receive it?

Courtney Rose: Then you select "no" within the Web interface, and you move to the next patient, and that's considered complete because you have answered the question within the Web interface.

Julie Nichols: OK. So it's considered complete, but is it considered satisfactory reporting?

Courtney Rose: So…

Julie Nichols: Or is it not?

Courtney Rose: It is if you got 411 or, you know, the 100 percent of the beneficiaries if there are fewer than 411. It's different—it is different than the individuals, and it's not—there is not a performance rate associated with it. It's a different term that we use, and that's like complete and completeness in reporting.

Charlie Eleftheriou: I'm sorry. This is—this is Charlie. I'm sorry to interrupt, but caller, if we could get your information, maybe someone could follow up with you since your question is so case-specific and detailed.

Julie Nichols: That would be great.

Charlie Eleftheriou: Thank you. If you wouldn't mind sharing your name and phone number?

Julie Nichols: Sure. It's Julie Nichols, and the phone number is 607-737-4273.

Charlie Eleftheriou: And your organization again? I'm sorry.

Julie Nichols: Arnot Medical Services.

Charlie Eleftheriou: OK. Thank you.

Julie Nichols: Thank you.

Charlie Eleftheriou: Alright. We'll take the next caller.

Operator: Your next question comes from the line of Amy DeBruin.

Amy DeBruin: This is Amy DeBruin at NEW Retina Associates. I have a question. Is CMS looking for us to continue claims-based reporting when the incentive and adjustment phases are over? Like for eRx, can we stop reporting on claims after June 30th of this year?

Molly MacHarris: Sure. This is Molly. So, for the e-prescribing program, remember, there are two reporting periods. The 6-month reporting period which you were referencing only applies for the 2014 e-prescribing payment adjustment. Again, we do strongly encourage folks to continue to report through the June 30th date, but we do just want to make you aware that you can still earn an incentive for the E-Prescribing Incentive Program. And the reporting period for that is through the end of this year. And as an individual provider, you would just need to report 25 instances—25 numerator instances—on the denominator-eligible claims.

Amy DeBruin: OK.

Molly MacHarris: And that's specific for the e-prescribing program. Again, for the PQRS program, we did finalize in last year's rule the criteria for the 2013 PQRS incentive, which does include claims reporting, and the 2014 PQRS incentive, which also includes claims reporting.

So we do strongly encourage folks to continue to participate in the e-prescribing program through the end of the reporting period. And for the PQRS program, if you've chosen claims as your option, while we have that option available, we do, of course, encourage you to report that way.

We do have other reporting options available as well, such as our EHR options. And just an important thing to note on those EHR option is that if you're trying to participate in both the PQRS program and the EHR Incentive Program, you can receive credit for the Clinical Quality Measure component of Meaningful Use if you electronically report your measures that way.

So, just some things you'll want to consider for the future. Does that help answer your question, or did I confuse you?

Amy DeBruin: Well, I'm not really sure. We've just started on EHR, and we haven't attested yet, and I'm just wondering, you know, is this something CMS is looking for us to continue doing forever, or was this just to get us in the habit of using electronic prescriptions?

Molly MacHarris: Well, so, again, the e-prescribing program, that does end after—the last reporting period for e-prescribing is the end of this calendar year. That program ends with the 2014 payment adjustment. However, the PQRS program, that program was made permanent a few years back, and the Affordable Care Act actually requires us to apply a negative payment adjustment if you are not a satisfactory reporter. So I do strongly encourage you to continue to participate in the PQRS program so you don't receive that negative payment adjustment.

Amy DeBruin: Correct, alright. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Jill Peck.

Jill Peck: Hello, I'm Jill Peck from Chelsea Community Hospital in Michigan, and I have a question regarding the PQRS group measure for the preventative care measures.

One of my primary care providers would like to know why the only codes that the group measures can be billed with are just the E&M codes, and why possibly the annual wellness visit codes aren't included in that, since some of her patients that she sees don't have medical issues to evaluate. So this would mean that if she billed out an E&M code with a V code, they would be responsible for the balance.

Kim Schwartz: PMBR, this is Kim from CMS. PMBR, can you please take that call—that answer?

Debra Kaldenberg: This is Debbie from PMBR, and my understanding—I don't have the specifications in front of me, but with the preventive care measures group, there are no diagnosis codes associated with it. So the patients that are denominator-eligible are denominator-eligible based on encounters, and then you report those measures within that group. And as far as certain codes not being in there, that would be up to the measure owner and things that they have requested. But I'd certainly be willing to both go to the measure owner and we can request some updated codes, or give you contact information for the measure owner.

Jill Peck: I guess it doesn't really answer my question because it says it needs to be billed with a CPT code, the office visit code.

Debra Kaldenberg: Right.

Jill Peck: And I understand there is no diagnosis associated with any of these measures, but because we would probably be putting on a V code, which is very generic, maybe a screening code for the office visit code, the 99201 or the 99211, the patient would be, I'm assuming, penalized because Medicare doesn't cover any kind of screening visits—office visits.

Debra Kaldenberg: OK. I'm not real sure. What I'd like to do, if you don't mind, I have your name, and I'd be willing to give you a call when I have the spec in front of me, if that would be alright.

Jill Peck: OK, sure. My number is area code 734-593-5728.

Debra Kaldenberg: Alright. I'll give you a call.

Jill Peck: And what was your name again?

Debra Kaldenberg: My name is Debra Kaldenberg.

Jill Peck: Thank you.

Debra Kaldenberg: Thank you.

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

Susan Benefito: Hi. Can you hear me?

Charlie Eleftheriou: Yes.

Molly MacHarris: Yes, we can hear you.

Susan Benefito: Thank you. Yes, my name Susan Benefito. I'm with Bradenton Endocrinology and—in Florida. And the PQRS question—yes, we are an individual doctor, and I was told that with us reporting three measures, I was told that we only needed to do 20 patients. And I'm seeing on this page 29 it has to be 80 percent of the group practice, or—80 percent of the practice, is that how I'm reading it?

Molly MacHarris: Sure. So you are reporting as an individual eligible professional, is that right?

Susan Benefito: Yes.

Molly MacHarris: OK.

Susan Benefito: Endocrinologist.

Molly MacHarris: And how are you reporting, through claims . . .?

Susan Benefito: Claims-based.

Molly MacHarris: OK, claims. So there're two options that are available. One is reporting three measures for 50 percent of the eligible patients. And then the second option is to report one measure group for at least 20 Medicare Part B patients. So it sounds like you are merging both of the options together, but they are separate and distinct. The measure groups—those measures

consist of at least four or more measures, and they are clinically related clusters, such as we have a diabetes measure group, we have a heart failure measure group, a COPD measure group. And we do find that providers do like that option, because it's a clear set of measures that are available.

And for the 2013 year, you would need to report those measures for at least 20 Medicare patients. Again, we do always encourage folks to report beyond that threshold just in case, for example, an instance or two got missed, but…. Does that help answer your question?

Susan Benefito: Well, we would do the diabetes group, and we would do—and then the measures—one measure group would be like the HbA1c, reporting on that.

Kim Scwhartz: Well, this is Kim from CMS. If you would be doing the diabetes measure group, then you'd need to report on all the measures that are within that group.

Susan Benefito: Do you understand that?

Susan Benefito: OK. No. I'm sorry. I am confused.

Kim Schwartz: That's OK. So, for example, if there are five measures within that particular measure group, then you need—you need to report each of those measures specific to a patient within your practice. And in this case, the measure group, the rule for 2013 is that you have to report on 20 patients. So you would need to identify 20 patients within your population, and for each of the measures within the measure group, they'd have to report it on.

Susan Benefito: OK. So that would be the HbA1c, the LDL, and the BPs?

Kim Schwartz: Correct.

Susan Benefito: OK.

Kim Schwartz: Every one of these measures stated within that measure group would be reported on for 20 patients within your practice.

Susan Benefito: OK. OK. Because I was—we were on 80 percent, 30 percent, and all of this. So it's just 20 patients. OK.

Molly MacHarris: Right. And if you have additional questions, again, we would encourage you to call the Help Desk. Their information is on slide 33, and they can help you get started on reporting on PQRS, and they can point you to some educational resources that we have available on our Web site that can help you get started on reporting.

Susan Benefito: Very good. Thank you.

Molly MacHarris: Thank you.
Operator: And your next question comes from the line of Marianne Lifrieri.

Marianne Lifrieri: Hi. My name is Marianne. I'm calling from Medical Arts Radiology Group in New York. It's a group of 14 doctors. We just started reporting on the PQRS, and I'm wondering how can I find out if our reporting is successful?

Molly MacHarris: Sure. This is Molly again. Are you reporting via claims?

Marianne Lifrieri: Yes.

Molly MacHarris: OK. One of the best ways that you can find out if your quality data code has been accepted by CMS is on your remittance advice, you will receive an N365 remittance code. And essentially it says that your quality data code, or G-code, wasn't processed for payment, but it was accepted to the CMS data warehouse for quality purposes. So as long as you see those N365s come back on your claims, then that is an indicator that those claims will be used for analysis on the PQRS program.

Marianne Lifrieri: But that doesn't mean—that just tells me that they've been accepted. It's not telling me that my reporting is successful.

Lauren Fuentes: And then this is Lauren. Another tool that we have available for claims-based reporting is that we do have an interim dashboard that you can access that. You have to log into the physician's portal.

Marianne Lifrieri: OK.

Lauren Fuentes: And when you log into that portal, you will have an option to view—to view a dashboard, and it will be updated on a quarterly basis so there probably wouldn't be anything available for you to view for 2013 until probably, I would say March—March or maybe April. And that will show you your, you know, kind of your reporting to date, and that's available for claims reporting.

Marianne Lifrieri: But again, that's just telling me that you've received my claims. I'm trying to find out if I'm successful, if I'm meeting the measures, that I'm—you know, where the physicians won't be penalized. How can I find that out?

Molly MacHarris: So again, to clarify, for purposes of the 2015 PQRS payment adjustment, the three ways that your providers cannot receive that negative payment adjustment is, one, to meet the incentive eligibility criteria, so three measures at a 50 percent reporting rate. The second way is to report one measure at least one time. And the third way would be to elect the administrative claims option. So some of the ways you can identify whether or not your providers will be—will or will not be subject to the payment adjustment, if you submit the quality data codes on a claim and you get the N365 back, you can use that information to help you understand that CMS has received that QDC code.

Additionally, as Lauren mentioned, we do have this dashboard report, which will be available closer to the March–April timeframe, and that will provide high-level information on the

measures that your provider has reported and what the reporting looks like to date. It will not provide specific performance information, but it will provide information on the measures that have been received to date.

Marianne Lifrieri: So I can go all year reporting and fail and not know it?

Molly MacHarris: No. The dashboard report does provide information on the claims-based measures that we've received to date and high-level information on how you have reported.

Marianne Lifrieri: OK. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Niva Lubin-Johnson.

Niva Lubin-Johnson: Hi. I've got a question about the Meaningful Use reporting and the NPI. I've submitted my Meaningful Use of 2012 earlier this year using my individual NPI, but my claims are submitted with my corporate NPI. And so, is there some way I can, you know, be able to submit what I've already submitted under Meaningful Use—for the eRx, in particular—reporting?

Molly MacHarris: So just to clarify, when you registered and attested for Meaningful Use, you used your corporate?

Niva Lubin-Johnson: No. Yes, I had to do my individual. But the thing is my—you know, my billing is done because I became incorporated after I had been in practice for a while. I'm a solo practitioner. So I became incorporated, so my billing goes through my—the corporate NPI number. And so when you said that the—for the PQRS reporting, you know, that it has to—the claims NPI have to be the same for that hardship to apply. But I didn't know this until hearing it from you, so how do I make, you know, the information I've already submitted be allowable for the eRx, you know, reporting?

Molly MacHarris: Sure. So we can do a couple of things. One, I would suggest that you contact the QualityNet Help Desk. Again, their information is…

Niva Lubin-Johnson: Right.

Molly MacHarris: … on slide 33, and they can raise this issue up to us here at CMS, and we can take a look at the information you provided to see what is going on with your particular situation.

Another piece that I would suggest that you do is if you go to our Web site, on the left-hand side of the page there's a Measures and Codes section. And on that site, there is a 2013 Measures Implementation Guide, and towards the back of that guide, it does include a sample CMS 1500 Claim Form, and it can tell you exactly where we would look to receive the individual/rendering NPI.

So you can bill under your corporate, or where we typically refer to it as your group NPI. But for us to attribute the quality of reporting to you as the actual provider, we need to receive the individual/rendering NPI, and I believe it goes on a specific line item. I don't know what that line item is. That's all in my head, but it does . . .

Niva Lubin-Johnson: So 1500 form?

Molly MacHarris: Yes. It provides a mockup of the CMS 1500 Claim Form.

Niva Lubin-Johnson: Right.

Molly MacHarris: It will tell you exactly where to put it. And another thing is, when you talk to the Help Desk, if you have questions on that, the Help Desk can help you with that as well.

Niva Lubin-Johnson: OK. And so, would this be putting—so would the sample 1500, would this be adding the individual NPI in addition to my corporate NPI?

Molly MacHarris: Yes. So remember, for PQRS purposes, if you're participating as an individual, we do need to receive that individual/rendering NPI. That's the way we can attribute the quality data that you …

Niva Lubin-Johnson: I just want to make—you're saying that both numbers would then need to be on the form?

Molly MacHarris: Yes. Both numbers would be on the form, and the sample claim form that I referenced does indicate where both numbers would need to go. And again …

Niva Lubin-Johnson: OK. And this information, even though I reported in '13 for '12, this would count towards the '13 reporting then, for the eRx hardship? Or do I have to—is it going to count when I do Meaningful Use Stage 2 this year?

Molly MacHarris: So, for the e-prescribing program, I would suggest that you have the Help Desk look into your particular case, and they can bring it up to us, and we can look into that particular instance if needed.

Niva Lubin-Johnson: OK. Alright. Thank you.

Molly MacHarris: Thank you.

Operator: And your next question comes from the line of Moojid Hamid.

Molly MacHarris: Hello?

Operator: Moojid, your line is open. And that question has been withdrawn. Your next question comes from the line of Sharron Thomas.

Sharron Thomas: I have a question regarding page 27 under the Individual Measures where it says "Qualified Direct EHR Product." We have attested and entered everything—our numerator and denominator—online. Will this suffice for PQRS?

Molly MacHarris: So, when you say you've attested, you're referencing the EHR Incentive Program?

Sharron Thomas: Yes.

Molly MacHarris: OK. Sorry. No, it will not suffice for purposes of PQRS. We do need to receive your EHR information electronically. So what these two options are referencing are the two ways you can do that.

Option 1 refers to the aligned option with the Meaningful Use Program. So when you go and register and attest for the Meaningful Use Program, there should be an option for you to participate in the PQRS EHR Incentive Program Pilot, and when you do that, you will be locked for pilot reporting. And once you are locked for pilot reporting, we will look to receive Clinical Quality Measure data extracted directly from your EHR that will need to be sent to CMS. And once we receive that, we could then give you credit for both the PQRS program and the CQM component of Meaningful Use.

The second option for EHR reporting is the traditional PQRS option, which is report at least three measures for 80 percent of your eligible patients. So, unfortunately, just attesting to Meaningful Use through the Registration and Attestation module will not be sufficient for PQRS purposes. We do need to receive the electronic submission of those Clinical Quality Measures.

Sharron Thomas: OK. Is it going to be sufficient for doing e-prescribe, though?

Molly MacHarris: For e-prescribe—so you did achieve Meaningful Use, is that correct?

Sharron Thomas: That's correct.
Molly MacHarris: OK.

Sharron Thomas: Yes.

Molly MacHarris: So, yes, that would be sufficient for e-prescribe. You want to look at the specific timeframe that we would look to have—for you to have achieved Meaningful Use throughout the year. Those are referenced on slide 12. So as long as you achieved Meaningful Use, then you would not be subject to the e-prescribing payment adjustment for the 2014 year, as long as you achieved it either from January 1st, 2012, through June 30th, 2013.

Sharron Thomas: OK. OK. Thank you very much.

Molly MacHarris: OK. Thank you.

Charlie Eleftheriou: Holley, I think this will be our last question.

Operator: **OK. Then your final question comes from the line of Tiffany Beaver.**

Tiffany Beaver: Hi, this is Tiffany Beaver from Community Health Network. But I have a question on the 2014 PQRS. Can I ask it or can I not? I can't get CMS—or I can't get the Quality Desk to give me the right answer, and I'm very, very familiar with both the EHR regs, Meaningful Use regs, and PQRS regs—I've read all of them. But if you—if I can't ask it, I understand.

Molly MacHarris: I mean, you can ask the question. We, unfortunately, can only speak to what was finalized in regulation, but feel free to ask your question, and we can answer …

Tiffany Beaver: OK. Sorry, I just—I just realized through all this while I was waiting that it's a 2014 question, but we're trying to plan now for it. So on page 69200 of the PFS Final Rule, they give a chart of the GPRO for EHR Direct. So—and then some sort of combining both that and Meaningful Use for Stage 2. So basically, it's reporting that we have over 100 providers, I've—we've already attested for over probably 500 for Medicare and Medicaid together. We have people in different stages, obviously. So my question is, you—we have—if you go this GPRO option for EHR Direct, say some of the provider—or say—so, say, we successfully do that for both the, you know, the quality measures and for the PQRS, does—does that include those people that are included in that? And I know you have to send batch files and so forth, but does that include the providers that are eligible providers for PQRS that are not part of the eligible providers for Meaningful Use?

Molly MacHarris: OK. So let me just make sure I'm understanding your question. So you're referencing table 28 in the Final Rule? The …

Tiffany Beaver: Table 93, which is the Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via GPRO for the 2014 Incentive.

Molly MacHarris: OK.
Tiffany Beaver: You know, and it's hard because when you go into it, it's—yes, it's hard because you can't navigate. I think it's like 328, I don't know. I don't remember the page, how it correlates …

Molly MacHarris: OK. So—so let me just make sure I'm understanding your question. So you want to make sure that if your providers are participating as a group practice, and they want to receive credit for both the PQRS incentive and receive credit for the CQM component of Meaningful Use, whether or not all of your providers in that group have to participate in both programs, is that correct?

Tiffany Beaver: Oh, it's kind of twofold, so I guess—well, threefold because I talked to our Medicaid HIT director on that. So first, I guess, one part of that question is, you have, say, the eligible providers for PQRS set as PAs, or clinical nurse specialists, or registered dieticians, clinical psychologists, social workers—those people that are not—that do not qualify for Meaningful Use. So therefore they wouldn't be—I mean, they wouldn't be individually

reporting. So would the group of just the MDs and DOs because it's for Medicare for PQRS—would those—assuming we report satisfactorily, would that also meet the PQRS for the entire group TIN?

Molly MacHarris: Sure.

Tiffany Beaver: I guess that's an easier way to ask—regardless if they participated in Meaningful Use or not, or regardless of their Medicaid, or regardless if they're in that first year, 1 year prior to a payment adjustment year, which would preclude them from participating as part of the GPRO.

Molly MacHarris: OK. So let me try to…

Tiffany Beaver: Does that make sense?

Molly MacHarris: I am understanding your question, which might be a little scary. So—so let me try to clarify what we finalized in the different regulations. So in the Meaningful Use Stage 2 regulation for eligible professionals, we finalized two ways that providers can participate.

Tiffany Beaver: Alright.

Molly MacHarris: One is that they can participate by reporting nine measures covering three domains. And then the second option is that they can participate by participating in PQRS, and as part of that participation in PQRS, they could be a group reporter.

Tiffany Beaver: Right.

Molly MacHarris: So a couple of things to keep straight is that for the Meaningful Use Program, the group reporting aspect of it only applies for the submission of CQMs. So to get back to one of the points you said earlier: Let's say, for example, you are a group of five—one TIN and 500 NPIs, and let's say only 100 of those NPIs have actually registered and attested for Meaningful Use, but those 100 NPIs say they want to do it as a group. And on the PQRS side, we received the quality data for all 500 of those NPIs.

For PQRS purposes, we would apply credit to all of the providers we receive under that TIN, and for any NPIs who bill charges under that TIN during the particular performance period. For Meaningful Use, however, they would only receive credit for those who have actually registered and attested for the other Meaningful Use objective.

Tiffany Beaver: Right.

Molly MacHarris: OK. So does that help answer the overall question?

Tiffany Beaver: I think so. So the PQRS—as long as we're submitting those batch files, then it will cover everybody within the group TIN that's potentially eligible for PQRS.

Molly MacHarris: Correct.
Tiffany Beaver: And then it will also have to—regardless of—and then even those providers who are precluded from being considered part of the group, so they have to individually report CQMs but can't do GPRO PQRS because . . .

Molly MacHarris: They wouldn't be—they wouldn't be precluded from participating as a group. It would more that every one of those providers would have to register and attest as an individual, and then they would have to elect for the CQM component of Meaningful Use, they want their data reported as a group. Because the only way that folks can participate in Meaningful Use as a group is for the CQM component. For all of the other Meaningful Use objectives, they have to participate and report individually. Does that—does that make sense?

Tiffany Beaver: You know, it does—right, right. But what—and I don't know the page number offhand. It would take me a couple of minutes to find—to pull up the document I created. But those providers that are 1 year—like if they're a 90-day—and it's tricky because then you get into 2014, and everyone's in a 90-day quarter-based reporting, so I don't know how the heck we can do GPRO for PQRS, you know, the GPRO EHR Direct in 2014, because we'll be on—it's 90 days, so I don't understand how that's going to work. So if you can maybe shed light on that—with that because nobody is going to be doing 90—an entire year reporting in 2014. You can't. So I'm just …

Molly MacHarris: Ma'am, you know what…

Tiffany Beaver: Yes.

Molly MacHarris: … I think might be best since we are at time—and, unfortunately, we are going to get kicked out of our room here at CMS—is if you can provide your name, contact information, and organization, our Help Desk will get in touch with you, and if they can't answer your questions, they will make sure that it comes to CMS staff up here so that we can get you the answers. So if you can ….
Tiffany Beaver: They haven't been answering it. I've already asked and they are like—they won't answer it. They're like, "It's a CMS question," "No, it's a PQRS question." But I'll give you my name. It's Tiffany Beaver, and I'm with Community Health Network in Indiana. And my phone number is area code 317-621-0965.

Molly MacHarris: And …

Tiffany Beaver: And then I can try posting … go ahead.

Molly MacHarris: Ma'am, when you open your Help Desk ticket, you can reference that CMS directed you to open the ticket on a National Provider Call, and that you would like your issue escalated, and we will make sure you get resolution.

Tiffany Beaver: Great. Thank you. I appreciate it.

Molly MacHarris: Thank you.

Additional Information

Charlie Eleftheriou: Thank you, thank you. That is all the time we have for today. If we did not get to your question—I suspect there are quite a bit of people we didn't get to their question—please contact the Quality Support Help Desk at 866-288-8912 from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday, or e-mail qnetsupport@sdps.org. This information is available on slide 33 of today's presentation.

Please note that while we may not be able to address every question that comes in, we will—we will review them all to help develop frequently asked questions, educational products, and future messaging.

On the last slide of today's presentation, you'll find an information—I'm sorry, you will find information and a URL to evaluate your experiences with today's call. Evaluations are anonymous and strictly confidential.

I should also point out that registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within 2 days of—business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you've already completed the evaluation. We do appreciate the feedback.

I'd like to thank everyone who participated in today's call. An audio recording and written transcript will be posted to the Physician Quality Reporting System and the National Provider Calls Web pages on the CMS Web site in approximately 3 weeks.

I wish everyone a good day, and thank you for participating. Thank you.

Operator: Thank you. This does conclude today's conference call. You may now disconnect.

-END-