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**Centers for Medicare & Medicaid Services
2013 PQRS and eRx Claims-Based Reporting Made Simple
National Provider Call
Moderator: Charlie Eleftheriou
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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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, Charlie. You may begin.

Announcements and Introduction

Charlie Eleftheriou: Hello, 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 titled "2013 PQRS and eRx Claims-Based Reporting Made Simple."

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 program. A link to the presentation and today's announcements was e-mailed to all registrants around noon today. If you did not receive the e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box. Or the presentation can also be found by visiting the CMS National Provider Call – excuse me, CMS National Provider Call's Web page at www.cms.gov/npc, as in National Provider Calls. Again, that's www.cms.gov/npc, then clicking on the National Provider Calls and Events link on the left side navigation panel, and then find today's call by date on the list.

An audio recording and written transcript of today's call will be posted to the National Provider Call's Web page within approximately 3 weeks. Next, a reminder that this call is being recorded and transcribed. Those speaking on the line today are asked to state their name and the name of their organization before commenting.

Lastly, please note that all pertinent resources and contact information related to today's call are available on slides 32 through 35 of today's presentation. With all that said, I'd like to now turn the call over to Christine Estella. Christine?

Presentation

The Physician Compare Web Site

Christine Estella: Thanks, Charlie. First I want to begin, and we don't usually provide announcements, but this announcement's not actually in your packet. So I'm just going to provide you with this quick Physician Compare announcement.

CMS will launch the redesigned Physician Compare Web site coming very soon. An Open Door Forum will be held in the coming weeks, and to register for the Open Door

Forum, please send an e-mail with your name, affiliation, and e-mail address to the Physician Compare team at physiciancompare—that's one word, so no space—@westat.com. So again, physiciancompare—one word—@westat.com. Please put ODF in the subject line.

Introduction to Claims-Based Reporting

So now after that announcement I'm going to go into our presentation. Our presentation today is about claims-based reporting. This is actually a pretty important presentation.

Just to give you guys kind of a background, you know, according to our experience reports, the claims-based reporting mechanism is the most widely used reporting mechanism, probably because it's the one that's free. And so – and it's also the reporting mechanism that, from what we've seen, that EPs have kind of stumbled on in terms of reporting G-codes. So for those of you reporting claims, let's go through how to report claims for 2013.

I'm going to start with slide 5. On slide 5 you have the advantages of claims-based reporting. First of all, it's readily accessible to all EPs as it is a part of the routine billing process. You do have to submit your claim in order to get reimbursed by Medicare.

There's no need to contact a registry or qualified EHR vendor for submission of data. So traditionally with registry or EHR-based reporting, you would basically have to wait. CMS usually either qualifies, you know, a registry or a product, and the EHR product has to be certified or qualified, depending on the year. And usually you'd have to wait for that list before you begin contacting the qualified or certified EHRs or registries. So at this – at this point you don't have to wait because you know you're going to use claims. You can start right away in January, whereas these registry/EHR lists don't really come out typically until the fall.

The third advantage is that it's simple to select measures and begin reporting. So basically what you're doing in claims-based reporting is you're attaching a Quality Data Code, a QDC, to a claim. So usually, you know, kind of one of those G-codes, like for example with the E-Prescribing Incentive Program, you're attaching a G8553.

On slide 7, "Claims-Based Reporting of Quality Data," Medicare providers submit claims via CMS-1500—that's the form that you use for reimbursement on billable services rendered to Part B beneficiaries. Eligible professionals use their individual rendering NPI to submit for services on Medicare Part B beneficiaries. So there's a difference between, you know, using a group NPI or an individual rendering NPI. For purposes of reporting for PQRS or the E-Prescribing Incentive Program, you're going – you're supposed to use your individual rendering NPI when you're reporting.

Claims follow a process so the information gets to the CMS National Claims History file, or the NCH. Standardized codes are found within each PQRS measure's specification and within the eRx Incentive Program measure's specification. Be sure to reference the

most current program measures specs and supporting documents as posted on the CMS Web site.

So basically this means that when you're – when you're reporting certain PQRS measures or the Prescribing measure under the eRx Incentive Program, you're supposed to report specific G-codes, and I guess whether or not – you can tell whether or not a claim or a reporting code has passed through the NCH. Usually traditionally there's kind of, you know, a signal; you'll have a code saying that, you know, you're reporting for – or you've attached a G-code for reporting purposes only. And it's an N365 code.

On slide 7 we kind of give you an overview of the claims-based process. So basically, you know, you visit documented – visit documented in the medical record. You have the encounter form, coding and billing, and then you're sending the coding information or reporting information to the carrier MAC or to the National Claims History file.

And, again, as you can see, above the carrier MAC you have that N365. That's the code I was talking about earlier—that you would check to see if you have the N365 code to make sure that your reporting went through. It doesn't specify which codes went through, but it specifies that at least you've had some reporting codes go through the NCH.

And the contractor analyzes the measures you report. You get, you know, an incentive, or you don't, based on whether or not you have successfully reported or satisfactorily reported, depending on the program.

You could also get a payment adjustment. For example, for the E-Prescribing Incentive Program you could get a payment adjustment for not reporting the E-Prescribing measure.

For PQRS, this year is the first year where we are using reporting data to assess whether or not an EP would be subject to a 2015 PQRS payment adjustment. So, definitely important to start reporting now in PQRS if you haven't already started.

And then at the end after, you know, incentive payments are dished out, traditionally we usually provide incentive payments around the fall of the following year. And soon after that you'll receive a confidential feedback report which will give you all of your claims history reporting data. So if for some reason you thought you should have gotten incentive and you didn't, you know, the first place you would look would be the – the feedback report.

On slide 8 we have the reporting periods for 2013. For PQRS there's a 12-month reporting period to earn the 2013 PQRS incentive payment and avoid the 2015 PQRS payment adjustment. I want to add, too, there's also a 6-month reporting period from July through December 31st, 2013. This is an alternative reporting period, but it only applies if you are reporting measures groups via registry.

So the reporting period is the same, as you can see, reporting period here 2013, for the 2013 PQRS incentive payment and the 2015 PQRS payment adjustment. For e-prescribing—we're actually nearing the end of the E-Prescribing Incentive Program, but we still do have reporting periods available. Actually the only reporting period that we have available currently is that 6-month reporting period (it's that second bullet), January 1st through June 30th, 2013, to avoid the 2014 payment adjustment only. And for the 6-month reporting period, you can report on each payable Medicare Part B Service.

Claims-based reporting is the only option for the 6-month eRx reporting period. If you wanted to report using registries or EHR, you would have had to use that reporting period of last year for the 2014 PQRS payment – or 2014 *eRx* payment adjustment.

On slide 9, “Reporting Frequency,” earning the 2013 PQRS incentive using claims: So this goes through the steps of reporting via claims. You report QDCs once per patient, per NPI/TIN combo, per reporting period. This is patient-level data.

So basically, let's say you have, you know, five docs in your office and you have, you know – they each have different TIN/NPIs, you would be reporting for each of their patients, for each of the docs. So, it's not – unless you're part of a Group Practice Reporting Option, you know, they would have individual reporting. You would have to ensure that you would meet the criteria for either satisfactory reporting for PQRS or e-prescribing – successfully e-prescribing for each doc that you have.

Second, you would report QDCs once for each procedure performed. You'd report QDCs for each acute episode and then report QDCs for each visit.

And here we have a blip about avoiding the 2015 PQRS payment adjustment using claims. So you would do the same thing as you were doing for the PQRS incentive except for – to avoid the 2015 PQRS payment adjustment you would only need to report one measure or measures group on a denominator-eligible patient via claims once during the reporting period.

And this is only to avoid the PQRS payment adjustment. You wouldn't be able to get the incentive if you only reported on one measure. The incentive criteria is a little bit more robust. It generally requires the reporting of three measures as opposed to just one. And you have to report on a multiple set of patients, you know, a certain percentage of your patients, depending on how many applicable patients – or how many patients are applicable to the measure.

Also on slide 9, earning the 2013 eRx incentive using claims: You'd report a QDC for each denominator-eligible visit. So this looks a little less complicated than the PQRS incentive, if you can compare the two, because the PQRS incentive – under PQRS you are reporting on – you can potentially report on hundreds of measures. We have approximately 300 measures within PQRS, whereas the E-Prescribing Incentive Program, you only have one measure, and that's that E-Prescribe – E-Prescribing measure. So it's

basically, you know – you state whether or not you use an electronic prescription, or you gave a patient an electronic prescription.

Avoiding the 2014 eRx payment adjustment using claims: You'd report QDC for each visit. So the difference between the 2013 eRx incentive and the 2014 eRx payment adjustment is that if you are reporting for the incentive, you would need to report on a denominator-eligible visit. For the 2014 payment adjustment you can report on any visit regardless of whether or not it is a denominator-eligible visit.

Sample Claims/Registry Specifications

On slide 10 we discuss sample specifications. So if we move on right over to slide 11, this is kind of a description or snapshot of what you'll see for a traditional PQRS measure. All of our measures specs are found online, but we have a huge manual. It's a zip file. It's pretty, pretty big; as I mentioned before, it's about 300 measures. So it has 300 measures worth of specifications. You don't need to look through all of them. Traditionally, when you're reporting under PQRS there's probably, you know, about three measures that you're used to reporting, or that, you know, the Help Desk or someone would advise you to report. So you'd probably typically only be reporting on like three measures. So you'd only be looking at the measure specs for those three measures.

So one of the measure specs is found here. As you can see, it's for 2013. You want to check the date of the measure spec because the measure specs vary from year to year, so what you're reporting in 2012 may not be the same as 2013. Make sure you're looking at a 2013 measure spec.

Also, you can report this via claims and registry. So here we're – since we're doing claims-based reporting, you're choosing to report via claims. There are a couple of sub-bullets here that kind of provide you with little descriptions about, you know, what certain symbols mean within the measure.

You definitely want to check the measure title. Do you have the right measure title? Some of our – we have a few measures that kind of, you know, talk about or – or report – or you're reporting on quasi the same condition, but the measure specifications are a little different. I would check on that as well.

So traditionally in a measure spec you have the measure title up top, you have the measure number. PQRS has a certain number that we've classified. And then you'll traditionally, if there – if it's NQF endorsed you'll have an NQF number next to it.

And then you'll have the description and instructions of the measure. The description kind of gives you more information about when you should be reporting the measure, and the instructions tell you more specifically, you know, for this one you're reporting once per reporting period for all patients with a certain condition.

On – slide 12 continues the example of the measure specifications. So under here you have measure reporting via claims versus measure reporting via registry. If you are using the claims-based reporting mechanism, clearly you would – you would look at the measure reporting via claims. So it would give you, you know, that you'd report on a CPT or a G-code.

On slide 13 you have the denominator of the measure. The denominator determines whether or not a visit is eligible to be reported for that measure. So you have all these – these denominators contain all the billing codes. So basically if you're billing, you know, that particular service, you could probably report that measure.

You're not going to get, you know – you're not going to get dinged for reporting a measure for, you know, a service that didn't apply to the measure. So I would – I would – certainly if you think that the measure applies to a particular service, I would certainly report—over-report rather than under-report.

On slide 14 you have the numerator in the measure spec. The numerator is actually what you would be reporting under claims-based reporting. So here you have patients with documentation at least once within 12 months of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care.

[It] provides you with a definition of certain terms within the numerator, and also, down on slide 15, that's where you have your reporting codes for the numerator. So, as you can see, they've circled the numerator codes, examples of QDCs. So if you want to report this measure, you would report on the claim, either, you know, CPT-II 5010F, G8397 and then there's also an option to report 5010F with 1P.

On slide 16, our specification example continues. So there's another – Measure 19 has two performance exclusion sections. So this also contains numerator codes that you may need to report, as does slide 17.

On slide 18, that concludes the end of the measure's spec, and remember, we're only looking at one measure specification. If any of this seems, you know, like – if any of this seems very foreign to you, I would urge you to contact the QualityNet Help Desk. I'll give you the information about that later, but at the end you'll traditionally have clinical recommendation statements related to the measure.

PQRS and eRx Sample CMS-1500 Forms

On slide 19, we'll have – begin going through the sample CMS-1500 form. So on slide 20 this is your traditional CMS-1500 form. This shows you, you know, let's start with 21, "Review applicable PQRS measures related to ANY diagnosis [Dx] listed in item 21. Up to eight [Dx] maybe entered electronically." So this is where you're entering the codes.

24D, “Procedures, Services, or Supplies.” “Modifier(s) as needed.” Some of those numerators have some modifiers like the ones with, you know, a 5010S, for example—that measure specification, that would be a modifier. Again, if you’re moving right, “QDC codes must be submitted with a line item charge of zero or a penny. Charge field cannot be left blank.” So you can’t – if you’re reporting, you can’t leave that claim – or that line item blank or else the claim would be rejected. If you put a zero and you – and the claim still gets rejected, then you would need to, again, go back and put a penny in order for your claim to be properly submitted. You wouldn’t get reimbursed for the penny but it’s just to note that, you know – it’s just to have it pass through the National Claims History file.

“For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line item in the PQRS calculations.” So that’s that column J, if you have more than one NPI billing.

And then on the bottom, 33a: “The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a [g]roup is billing, enter the NPI of the [group] here. This is a required field.” Now traditionally for PQRS you’d be using individual rendering NPI.

I’m going to skip to slide 22. Slides 22 and 23 kind of give you, you know, a more detailed overview and zoom up the different examples that we’ve gone under – under claim – or that we’ve discussed on the CMS-1500 form. So I’m going to move over to slide 24, “How to Start Reporting via Claims.”

“There’s no registration required, simply start reporting the QDCs listed in the measures you have selected on applicable Medicare Part B claims. Review the *2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure [Specifications] Manual* for measures that are applicable to your practice.” That’s that measure specs manual that I had mention earlier that’s, you know, it’s pretty big in volume, but you’d only be looking at, you know, three or so measures or one measures group, depending on what you’re reporting.

“Review *2013 Physician Quality Reporting System (PQRS): Implementation Guide – Claims-Based Reporting for the Incentive*.” This implementation guide is actually pretty helpful, especially if you’re a first-time reporter. Gives you a little bit of an overview over, you know, your claims-based reporting options, how to report. There are different ways to report under the claims-based reporting mechanism. So if you are looking to get started with claims-based reporting, the implementation guide would probably be a good thing to at least peruse over.

Helpful Hints

Helpful Hints: On slide 26 we have a couple of helpful hints for you. One is to report the QDC on each eligible claim. “Failure to submit a QDC on claims for these Medicare patients will result in a ‘missed’ reporting opportunity that can impact incentive eligibility and payment adjustment subjectivity.” It’s what I mentioned earlier, that you’d

probably try to over-report rather than under-report. So even if you're unsure as to whether or not the measure applies, I would put the G-code on, the reporting G-code on anyways. You're not going to get penalized for, you know, not properly reporting, but if you don't report the measure and it is applicable, then, you know, that would result in a missed reporting opportunity.

“Avoid including multiple dates of service and/or multiple rendering providers on the same claim. This will help eliminate diagnosis codes associated with other services being attributed to another provider's services.”

“For measures that require more than one QDC, please ensure that all codes are captured on the claim.”

“If all billable services on the claim are denied for payment by the carrier or MAC, the QDCs will not be included in program analysis.”

“If the denied claim is subsequently corrected and paid through an adjustment, reopening, or the appeals process by the carrier or MAC with accurate care codes that also correspond to the measure's denominator, then any applicable QDCs that correspond to the numerator should also be included on the corrected claim.”

“All claims adjustments, reopenings, or appeals processed by the carrier or MAC must reach the national Medicare claims system data warehouse by February 28, 2014, to be included in the analysis.” So when we go through that full-year reporting period, you need to make sure that all [inaudible] claims are in 2 months afterwards, February 28th. That's traditionally been the deadline to have claims submitted for reporting purposes.

“Claims may not be resubmitted solely to add or correct QDCs.” So if for some reason you put in, you know, a wrong G-code or a wrong number, you cannot then go – and it's passed through the NCH, you cannot then go back to try and re-amend the claim to put in the corrected code. We do not allow for the re-submission of claims for reporting purposes.

“Claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the carrier or MAC.”

On slide 28: “The Remittance Advice /Explanation of Benefits denial code N365 is your indication that the PQRs and/or eRx codes were received into the National Claims History file. N365 reads, ‘This procedure code is not payable, it is for reporting information purposes only.’”

“The N365 denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC is valid for the measure or that incentive quotas were met. When a QDC is reported satisfactorily (by the individual provider), the N365 can indicate that the claim will be used for calculating incentive eligibility.”

So that basically says what I've stated previously, was that even if you see the N365 code, it doesn't guarantee that it was the G-code for that specific measure that you were intending to report. N365 means generally you've put in a general reporting code that we recognize, and we see that it's for reporting purposes.

“Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the carrier or MAC. Each QDC line item will be listed with the N365 denial remark code.”

So for every – for every – for every QDC that you report you will get an N365 denial remark code. So if you're reporting on more than one measure, you will see the N365 for each measure reported.

On slide 29 we have a satisfactory reporting scenario. These folks are trying to report Measure 6, Coronary Artery Disease, Antiplatelet Therapy. Mr. Jones, age 65, presents for office visit, and that's the billing code 99213, with Dr. Thomas. Mr. Jones has a diagnosis of coronary artery disease, \$414.

Scenario 1: Dr. Thomas prescribes aspirin or clopidogrel. You put in the code 4086F.
Scenario 2: Dr. Thomas does not prescribe, so then there are a couple of different scenarios with that. You can use: 4086F with 1P, 4086F with 2P, 4086F with 3P.
Scenario 3: Dr. Thomas does not prescribe and does not specify the reason why. You would use 4086F with 8P.

All of these 4086F codes are found in the measures box under the numerator portion of the measure specification for Measure number 6. So just depending on the different scenarios, those are the different codes that you'd be using when reporting and using billing code 99213.

Slide 30, “Tips for Satisfactory Reporting.” “Review all denominator codes affecting claims-based reporting, particularly those measures that do not have an associated diagnosis. You'll need to report on each eligible claim as instructed in the measure specs.”

“Review all diagnoses (if applicable) and CPT service (encounter) codes for denominator inclusion in PQRS/eRx,” meaning “claims that are denominator-eligible.”

“All denominator-eligible claims must have the appropriate QDC(s) or QDC with the allowable CPT-II modifier along with the individual eligible professional's NPI.”

“Use the measure specifications for the current program year and report as instructed for PQRS and eRx.”

Key points to take away, on slide 31: “Use the current PQRS and eRx Incentive Program information available on the CMS Web site. Review the respective detailed measure specs to determine the appropriate code(s) to place on the eligible claim.” Now

remember, for this year, then, you're reviewing measure specs for 2013, not measure specs from previous years, and measure specs could have changed from year to year.

“QDCs must be submitted on the same claim as the billing code(s), for the same beneficiary, for the same date of service, by the same eligible professional who performed the Part B covered service provided under the PFS. Claims may not be resubmitted solely to add QDCs!” And also “check your remittance advice for the N365 code to confirm receipt of QDCs into the NCH.”

Resources

On slide 32 and following, we have some resources for you. First and foremost, we have the program Web site—so PQRS and eRx Incentive Program Web sites—and a couple of bullets as to what you would find in those Web sites.

We have the provider listserv, frequently asked questions. Here's a list of acronyms for the PQRS and eRx Incentive Programs.

On slide 35, as I mentioned earlier, if all of this seems confusing to you, please feel free to contact the QualityNet Help Desk. Their phone number is 866-288-8912. They can help you. If it's your first time reporting, they can help you get started with reporting. They can help you if you're unsure how to report a particular measure and you've reported before. If any of the measure specs that you were reporting last year have changed and you just want to know if that's – you just want to know, you know, the Help Desk would be able to research that information for you.

We also have contact information for the provider contact center, as well as the EHR Incentive Program information center. Sometimes, reporting criteria with the eRx Incentive Program and the EHR Incentive Program kind of align, or there is also some alignment with PQRS but not particularly with claims-based reporting, but should you need the EHR Incentive Program information center contact information, you can – it can be found on slide 35.

That's the end of my presentation. So I'll turn it over to Charlie.

Keypad Polling

Charlie Eleftheriou: Alright, thank you. 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 of the provider community are receiving this valuable information. We're ready to start keypad 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, 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're holding, I'd like to 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 your organization.

Also, 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 have more than one question, please press star 1 to get back in the queue, and we'll address additional questions as time permits.

We'll take the first Q&A question as soon as keypad polling is finished.

Operator: Thank you, Charlie, and please continue to hold while we complete the polling. Thank you, this does conclude today's polling session.

Question-and-Answer Session

Operator: We'll now move into the Q&A session. To ask a question press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to ensure clarity. And please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference.

And your first question comes from the line of Gail Wilson.

Gail Wilson: Yes, I was just wondering: We were not able to start this on January 1. Will we be penalized for that? And can we go ahead and start it now?

Christine Estella: Sure. This is Christine. So as I indicated earlier, and you'll see it on the slides, too, it's OK that you're starting late. It's March. For the payment adjustment you only need to report one measure. So you only need to be reporting on one measure, so if you report the once and it's valid, that would be enough to get out of the payment adjustment.

You can still also definitely still try to report for the incentive. For claims-based reporting you need to only have reported on 50 percent of your applicable visits for each measure. So if you're reporting three measures, for 50 percent of the applicable visits.

Gail Wilson: OK, so we only have to report on 50 percent of our business?

Christine Estella: No, not your business; the applicable visits. So, like, for example, if you're looking at that doctor example, that's reporting Measure number 6.

Gail Wilson: Yes, ma'am.

Christine Estella: And that's – that's an actual applicable visit, and it has the billing code 99213, and that's how you would know if a visit's applicable (on slide 29). So basically, what you would do is you would see if a visit's applicable. If it is, then you would report, and we would only, you know – you would only need 50 percent of those applicable visits. So it's not your entire visits – business.

Gail Wilson: OK. Now if we set up these codes that – the G-codes that go with the regular CPT codes, will it hurt to over – over-report?

Christine Estella: No, it never hurts to over-report, and in fact I'd probably encourage over-reporting. Traditionally what we've seen, why people fail is because they thought that they weren't supposed to report on certain measures or certain visits. But, like when we do our analysis, it looks like they were – they could have reported, and that would indicate a missed opportunity to report, so that wouldn't go towards your 50 percent; it would count against you. So, certainly, over-report.

Gail Wilson: OK, and we do have to report on three measures. We have some chiropractics – chiropractic doctors – and I could only see on the chiropractic where they could report two measures, but maybe I'm not reading it right.

Christine Estella: That's not traditionally the case. Just because it's not a chiropractic-specific measure doesn't mean you can't report on the other measures. And that – that's applicable to everybody. Like, for example, we have our HHS Million Hearts measures, that is like a recommended core, and traditionally most – most people can report those HHS Million Hearts measures.

Gail Wilson: OK.

Kim Spalding Bush: And this is Kim, also from CMS, I'm the Measure Lead for the program. You also have the Medication Reconciliation measure that you're able to report on.

Gail Wilson: Oh, OK.

Kim Spalding Bush: As well as some of the smoking cessations.

Dan Green: And BMI would be another.

Kim Spalding Bush: Correct.

Gail Wilson: Right, OK.

Christine Estella: Yes, those, the smoking cessation and BMI I think are in HHS Million Hearts.

Gail Wilson: Well, of course, your chiropractors, they don't do prescribing because they can't prescribe medication, but we can pick up, you know, the other codes.

Dan Green: Well, you know, even though they may not prescribe, I'm sure we would all agree it's reasonable for any practitioner who's seeing a patient to inquire about the medications that the patient's on. I mean, if there are any recommended treatments, for example, some of the medications may be – have a contraindication to one of the given medical treatments. For example, if a patient's on a blood thinner, you know, there could be certain manipulations or certain other types of recommendations, stretching exercises, particularly if a patient's at risk for falling, that may not be the best thing to do, again, given the medication the patient may be taking.

Gail Wilson: Right, you're exactly right on that. I hadn't thought about that. OK.

Christine Estella: Yes, so if you need more help on reporting, definitely contact our QualityNet Help Desk. They can at least get you set up with those three measures that you want to report.

Gail Wilson: OK. I certainly appreciate it. It was a very good presentation today.

Christine Estella: Thank you.

Gail Wilson: Thank you.

Operator: And your next question comes from the line of Melody Nachtwey.

Melody Nachtwey: Hi, my question is regarding the reporting one valid measure for one eligible patient to avoid the adjustment.

Christine Estella: Sure.

Melody Nachtwey: If a provider has never reported PQRS, and they're going to attempt to report successfully for the incentive, but they fall short, will they still avoid the payment adjustment because they reported at least one for one patient?

Christine Estella: Yes, yes, as long as you report one measure for one applicable patient, and it's – I would – again, I would definitely make sure that when you're reporting, the N365 code is passing through.

Melody Nachtwey: Sure.

Christine Estella: Then, yes, they – they would get out of the payment adjustment.

Melody Nachtwey: OK.

Christine Estella: I would definitely encourage you to, you know, report for the incentive, because you can still get money reporting under PQRS, which may help you out later for future years. Because I think we moved – we have one more incentive in 2014, and after that, that's it for the incentives.

Melody Nachtwey: Right. I have another question. If we have this provider who's never reported before, and he's unsure which measures he qualifies for, can the Help Desk look at their claims history and help them decide that?

Christine Estella: Not actually like – not to analyze your specific claims history, but you can provide – if you were going to call the Help Desk, for example, on behalf of the provider, you can probably give them some general information as to, you know, what types of services your practice renders. You know, for example, if the guy's a radiologist, for example, but performs other functions within the practice. I don't know. You could – you could probably – the Help Desk would be able to guide you in terms of what measures to report for that provider.

Melody Nachtwey: OK. One last question: Do you know when the administrative claims mechanism will be announced, how that will work, and when they can elect it?

Christine Estella: Sure. So the caller is talking about administrative claims, and for admin claims, that's a new reporting mechanism for 2013. It's certainly different from the claims-based reporting mechanism that we've chosen – that we've talked about today here.

Admin claims: Basically, you're not reporting G-codes, so you're not attaching G-codes to a claim. Rather, you pass the claims on. You elect to use the admin claims-based reporting mechanism, and then CMS would actually calculate your claim – would look at your claims to see whether or not any of the measures fit within the services that you bill on the claim.

I do not have a date specifically as to when the election mechanism will be up, but we will be providing that announcement when it does come up.

Melody Nachtwey: OK. Thank you.

Christine Estella: Sure.

Operator: Your next question comes from the line of Sandy White.

Sandy White: This is a question regarding e-prescribing. If a PA – if we have one physician, and he's reporting under e-prescribing, and we have a PA in our office. So if

the PA sees the patient and bills incident-to, can we use that office visit to count toward our e-prescribing?

Dan Green: So, is the – you're billing under the physician's NPI, is that correct?

Sandy White: Yes.

Dan Green: So, if you're billing under the physician's NPI, and an e-prescription was generated, that should count towards your – toward the doctor.

Sandy White: OK, and are – are there any requirements – like we're not Electronic Health Records, but do we have to – does his – does his signature have to be in the chart? Say if we got audited or anything, would his signature have to be on the prescription that we put in the chart?

Dan Green: The doctor, you mean?

Sandy White: Yes.

Dan Green: No.

Sandy White: OK. Thank you. That's all. Thank you.

Dan Green: Thank you.

Operator: And your next question comes from the line of Cel DeRosa.

Cel DeRosa: Hi, this is Cel from LS Billing, and I have a question regarding e-prescribing. Because it says on the e-mail that you sent that individual professionals need to send eRx via claims from June 1 – January 1 to June 30. What is the GPRO? What does that mean? "eRx GPRO with 2220 for eligible professionals need 75 eRx."

Christine Estella: Sure, the GPRO is the Group Practice Reporting Option. So I guess you have different options in terms of how to report. For the – if you're reporting, though, as an e-prescribing GPRO, you would have had to self-nominate by January 31st of this year. So actually that deadline would be over, but did you self-nominate at all to participate in GPRO?

Cel DeRosa: No – no, so – so we will report it via the individual professional then?

Christine Estella: Yes, that top – that top option under that announcement, "Individual EPs would report 10 eRx events via claims."

Cel DeRosa: So it's – that's the minimum to – to not get the adjustment, right?

Christine Estella: Yes, yes, and then it's for each individual eligible professional in your practice.

Cel DeRosa: OK, and – and, oh, each individual professional can – can – e-prescribing. OK. And what if the other doctors are not e-prescribing? Will we get penalized?

Christine Estella: If the other – if you have, like, some docs that are e-prescribing and some docs that are not, you know, for the docs that are e-prescribing you'd report the Electronic Prescribing measure because they are e-prescribing. If you have docs that are not e-prescribing, they would get the payment adjustment unless a significant hardship exemption applies. We have, I think, about six categories where somebody may request a hardship. If you contact our QualityNet Help Desk at the number on that slide . . .

Cel DeRosa: Yes, I have it.

Christine Estella: . . . 5 – they'd be able to determine whether or not any of the exemptions apply to you, and they would help you to submit those requests.

Cel DeRosa: So the adjustment will only go to the – to the provider that's not e-prescribing, right?

Christine Estella: Right.

Cel DeRosa: OK. OK, thank you. That's all.

Christine Estella: Sure.

Operator: Thank you. And your next question comes from the line of Michelle Phillips.

Michelle Phillips: Hi, this is Michelle Phillips for Dr. Mark Phillips. We're a first-time reporter and we do neuropsychological evaluations, so we're going to report on the dementia group. I have questions primarily about Measures 286, 287, and 288, and the reference materials indicated we can access the materials on the Web site from the American Medical Association, but we weren't able to do that. They're not available to us. So that's one issue that I've run into.

The other is, particularly in terms of the driving question, if we're not able to report that we did counseling with the driving question, which is the first category, is that then going to count against us?

And we're hoping that we can do, the ones that we turn in anyway, that we can do the composite code. Sometimes Dr. Phillips will talk with patients about their driving issues and just reinforce that they're not driving. Would that be considered counseling?

Debra Kaldenberg: This is Debra from PMBR, and as far as counseling for driving, as long as the doctor is counseling the patient, even in that manner, that would be

considered appropriate. You would want to report something on each of the measures within that measures group at least one time. However, you don't want to have one of those measures where you never report, because that would end up being a zero percent performance, and you would fail that measures group.

Michelle Phillips: So that would even be if we did the composite?

Debra Kaldenberg: Well, you can only use the composite code if you do a Quality Action Performance Met on each individual measure within that measures group for that encounter.

Michelle Phillips: OK. What about those materials from the American Medical Association? How do we access that?

Debra Kaldenberg: Well, honestly, our suggestion would be that you use the materials that CMS has posted on their Web site, because those would be the most up-to-date and applicable for reporting in this measures group. But if you do have some specific questions outside of this, I would say to open up a QualityNet Help Desk ticket, and we can help you through that measures group even further.

Michelle Phillips: OK, well – and those were the – under those three categories CMS did, in the specifications manual, did indicate those were available, but I couldn't get them. So – but I can call the QualityNet desk again.

Debra Kaldenberg: Right, that would be great. If you go ahead and open up a ticket, we'd be able to help you.

Michelle Phillips: OK. Alright, thank you so much.

Operator: And your next question comes from the line of Cathy Fisher.

Cathy Fisher: Hello. My question is about – I had spoken with someone on the QualityNet, and they – when I was reading more information, I found out about, like, calculated administrative claims reporting. Can you explain what that is?

Christine Estella: Sure, the calculated administrative claims is the admin claims-based reporting mechanism that I had mentioned earlier. It's not claims-based reporting, so it is not – it's different from the claims-based reporting that we discussed in this presentation.

Basically, what an EP or a group practice would do is they would elect to use the administrative claims-based reporting mechanism, and this would only be for purposes of the 2015 PQRS payment adjustment; it does not apply to the incentive. And what CMS would do is that when you submit claims for services, we would analyze your claims to see whether or not any of the services fit any of the measures within the specific administrative claims-based measure set.

Cathy Fisher: So, basically, I have a very small practice of speech, occupational, and physical therapy. And so I guess what I've heard today is that we're not too late to go ahead and start reporting, and at this point as far as the time it seems like it's going to take to get the incentive, I'm just really interested in just being able to avoid the adjustments. And so basically I just need to report – each one of my therapists needs to report on one client for this year. Is that what I'm understanding?

Christine Estella: Yes.

Cathy Fisher: OK.

Christine Estella: You could still try for the incentive. I mean, we're only like a few months in, so it's certainly possible. And if you don't want to use claims, you could always use a registry or EHR, where that way the – an intermediary would basically go in, get all your data, and send it to CMS on your behalf. So technically your practice wouldn't have to do any work in terms of reporting codes.

Cathy Fisher: We're doing paper claims with that right now. We don't go through a registry, so we would have to then find a registry and pay somebody to do that. Is that my understanding? Right? There's no free way to do that?

Christine Estella: Not that we know of, no.

Cathy Fisher: OK, if we do go to electronic billing or reporting, do – I mean billing – do those types of registries then do this, or is it a totally separate type of registry?

Christine Estella: We have a list of qualified registries that come out, but no. But we do have a list of registries that come out like – it'll come out in the fall – to be qualified to report data for this year.

Cathy Fisher: I know through the NOMS, through ASHA, that I can do that for speech, but just PT and OT, I can't find any way to – to do it, and they don't seem to have much information through those associations. So it's been kind of a – a dead end. So, but basically – so the calculated administrative claims reporting—I mean, if I'm just trying to avoid the adjustment, is that something that is feasible or possible?

Christine Estella: Yes, that's something that you can elect to use.

Cathy Fisher: OK, and then how does someone elect to use that?

Christine Estella: We would provide more instruction on that, but there would be somewhere where you would go to elect. I don't have the Web site or links, or it's not available yet. So you would go on it – on – I think it's via the Web, and you would elect to use admin claims. And you'd probably put your basic information in there.

Cathy Fisher: And when do you think that information might be available, to be able to find it?

Lauren Fuentes: Hi, this is Lauren. We expect that to be – the Web site itself I think will be available in July. So I think, you know, late spring, summer, you know, definitely look for information about that opportunity.

Cathy Fisher: OK, thank you.

Christine Estella: Just remember, too, that the admin claims–based reporting mechanism is only finalized for this year. So – and we do have future payment adjustments coming for PQRS, so it may be advantageous for you to try and report anyways to see what you get – see if you get that N365 code while you're waiting.

Cathy Fisher: OK, I'll try. Thank you.

Christine Estella: Sure.

Operator: And your next question comes from the line of Teri Miller.

Teri Miller: Hi, I – this is Teri Miller, I think I've gotten most of my questions answered by just listening, but we are going to report for PQRS for the first time and going to do just the 6-month reporting from July through December. So my understanding – it can only be reported through registry only, is that correct?

Debra Kaldenberg: Are you referring to the measures groups?

Teri Miller: Correct.

Debra Kaldenberg: You can report the 6 months through – through a registry, but it's actually the exact same thing if you do the 12 months through a registry. So you could start at any time and report those measures groups.

Teri Miller: But if we just chose to do July through December, because really, honestly, we're not quite ready yet?

Debra Kaldenberg: Well, the registry is going to pull your information at the end of the year, so if you kind of look at some of the measures groups that you're – you're looking at the possibility of reporting, your incentive payment is going to be based on all 12 months and . . .

Teri Miller: Oh, I see.

Debra Kaldenberg: If you'd like, though, if you would want to open up a QualityNet Help Desk ticket, we'd be able to kind of help you get started with that.

Teri Miller: I will do that.

Debra Kaldenberg: Alright.

Teri Miller: Thank you.

Dan Green: You would want to elect 12 months reporting even if you collected all 20 of your patients, because it's a finite number of patients, it's not a percentage. So if you collected all 20 of your patients the third week of December, you know—let's say you're a busy diabetic practice and that's what you were reporting on—you know, if you still elect for the full-year reporting, you could earn an incentive based on your full year's charges, as opposed to 6 months' worth of charges. And even though you collected them in the second 6 months of the year for that 1 week, again, it still satisfies the requirements of 12 months because you've collected 20 patients.

Teri Miller: OK, that makes sense.

Dan Green: So it's to your benefit to elect the 12 months even if you don't start reporting through a registry, let's say, until, you know, August.

Teri Miller: OK, so there is no incentive payment for the 6 months for this year?

Dan Green: Well, there would be an – I mean, I don't know why anybody would want to do it, but you could elect 6 months, and then you'd get, you know – if you're – if you would otherwise be entitled to a thousand-dollar incentive payment, you would get \$500, roughly, you know, which would be silly. Of course, you'd rather . . .

Teri Miller: Right. Right. So when you go through a registry – and I understand that all the vendors are not posted, or will not be posted until later in the year, is that correct? A qualified registry?

Dan Green: (Diane), are the qualified registries out now for 2013? Sorry, we're having an internal discussion for a sec.

Teri Miller: Oh, that's OK.

Dan Green: Yes, the 2013 qualified registries are up – are listed on the Web site now. There may be minor modifications as the year goes on in terms of registries electing to report additional measures, but by and large it is – they're up there now.

Teri Miller: OK. Great, thank you.

Dan Green: Thank you.

Operator: And your next question comes from the line of Michele Bonge.

Michele Bonge: Hi, this is Michele Bonge with Nebraska Veterans Homes, and I have three questions actually. The first one is, I heard on another webinar in regards to PQRS that – that we could only report from an ONC-certified system for PQRS, is that true?

Christine Estella: Say, for – if we're talking about 2013, actually certification is – doesn't really have anything to do with PQRS. We do have a pilot where you would, you know, get EHR Incentive Program credit and PQRS credit if you're using certified EHR technology plus a qualified EHR. But that's a little different. So for 2013 are you reporting via EHR?

Michele Bonge: We haven't started reporting yet.

Christine Estella: Oh, OK, so, I mean, you don't need to report using a certified EHR technology for PQRS. There are a few reporting mechanisms; the first one I had mentioned, which is what this presentation is about, is claims. Second is registry, and third is EHR—it's either a direct EHR/EHR data submission vendor. That's kind of where in 2014—next year not this year—we would require that they become – that they are certified, but right now the EHRs only have to be qualified under PQRS.

And then we also have that admin claims-based reporting mechanism that I had mentioned earlier, but that is only for the payment adjustment, whereas the others are for both the incentive and the payment adjustment.

Michele Bonge: OK. And I have another question. If we have providers working from their own clinic, where they work – they have their own facility that they work out of, and then they come into our homes and to our clinic, and they also see members. Can a provider report via their clinic, and also we report PQRS and E-Prescribing measures on them?

Dan Green: It really depends on how they're billing. So if, when they're in your clinic, they're billing under your tax I.D. number?

Michele Bonge: Yes.

Dan Green: They could – you know, you would combine that tax I.D. with their NPI and, you know, if they earned PQRS incentive for the times they're visiting your center, you would get the payment because we pay it to the TIN of record. In their private practice they could also do PQRS, and they'd be billing under their own tax I.D. number, presumably, with their – with their NPI, and we would pay – if they earned an incentive there, we would pay them a separate incentive under their individual TIN/NPI.

Michele Bonge: OK, and then my last question is, on slide 6 you mentioned the eligible professionals use their individual rendering NPI to submit their services on Medicare Part B beneficiaries. So does that – if we bill under a group NPI also, can – where the CPT codes and the category II codes and G-codes are, that would have the NPI number of the

provider. And then at the end, can we have our group NPI number at the end of that claim?

Christine Estella: Hold on a second. PMBR, could you answer that question, please?

Dave Messenger: Yes, your – all your Part B claims, you would – would be putting both of those on there, the group NPI, so that they know who to – who to pay to. That's the billing or provider NPI. But you are going to have also the NPI of the rendering provider for, you know – associated with – with each line item for the services rendered. So it's – it's both.

Michele Bonge: OK, great, thank you.

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

Tina Shaffer: Hi, my name's Tina Shaffer. I'm calling from Neuropsychiatric and Counseling Associates. My question is that we had billed for e-prescribing last year, and we were wondering, when do we get an incentive? Because one of our providers already got the penalty this year, but we haven't heard anything as far as the incentive for the other provider.

Christine Estella: Sure, OK. So you're reporting – you reported last year in 2012. For the incentive you probably won't hear back until about the fall of this year. You would get your feedback report, that has the whole full year's reporting, shortly thereafter as well . . .

Tina Shaffer: OK. And then – oh, sorry. Go ahead.

Christine Estella: Sorry, I would say we're still doing the analysis, so . . .

Tina Shaffer: And so the provider that got the penalty—we had collected all of the EOBs to show that the claims were actually processed correctly, and we have submitted I guess a – like a – I guess a – I don't know what it's called exactly. PQRS, the – the Help Desk told me what to do, but, you know, it takes like 90 days for them to come back with a decision as to whether or not they will accept the proof that we have showing that we should not be penalized. Have you had any other providers running into that?

Christine Estella: Sure. So I believe what you're discussing is the eRx informal review process . . .

Tina Shaffer: Yes.

Christine Estella: We just added a deadline for EPs to submit a request for an informal review. That ended February 28th, 2013. Basically, CMS has about 90 days to render a decision to you. And that's the time frame for the requests.

As far as, you know, how long it'll take us to – you know, if you were – if you were denied, then, you know, that decision would be final. If your request was approved, then, you know, you would have to allow for adequate time for your claims would be – any claims that were adjusted to date would be reprocessed, and then you would stop seeing the payment adjustments.

Tina Shaffer: Oh, OK. So they will readjust the claims that they've already been penalizing us on?

Christine Estella: Yes, or they will reprocess. They will reprocess the claim.

Tina Shaffer: OK.

Dan Green: So the penalty that you're getting in 2013 could have been avoided, conceivably, for successful reporting. That means 25 e-prescribing events in 2011, or 10 e-prescribing events in 2012. So – and you're receiving the penalty right now, correct?

Tina Shaffer: Yes.

Dan Green: OK, so, similarly, as – as Christine said, for the 2012 program year for – as far as incentives go, that's a little bit of a separate calculation that we do. And we run that with the rest of our calculations for incentives for PQRS. So that information will be coming out late summer or early fall for the incentives.

In the meantime, as Christine said, if you think that your provider was inappropriately penalized, again, that informal review that she was talking about is the venue for you to have that reconsidered.

Tina Shaffer: OK, thank you.

Dan Green: Thanks.

Operator: And your next question comes from the line of Janet Scott.

Janet Scott: Yes. I have a question in regards to the e-prescribing. Last year one of our doctors was penalized the – on all of his patients regarding the e-prescribing. And I just need to know: We filled out the paperwork—or the hardship, I guess—so they're not penalized for 2013. How far in advance to we have to fill out the hardship for 2014? And when and if – or when and – when are they going to stop penalizing the doctors for not doing the e-prescribing, or are they ever going to stop penalizing?

Christine Estella: Sure. So each payment adjustment is for each year, so when you were talking about your doc getting penalized last year?

Janet Scott: Yes.

Christine Estella: That was the 2012 e-prescribing payment adjustment. So that payment adjustment would have already ended. That was a reduction of 1 percent. This year, for the E-Prescribing Incentive Program the reduction for the 2013 payment adjustment is 1.5 percent. So are you seeing that one?

Janet Scott: No, they filled out a hardship, and they haven't been taking any reduction.

Christine Estella: OK, great. So then that – so then the 2012 one's over. 2013, you're good. For the 2014 payment adjustment, actually the Communications Support page is currently open to accept those requests currently. So you can put in your request now if you want. And then obviously CMS will render a decision on your request, and I think that page closes June 30th of this year. So probably do it sooner rather than later, because sometimes, you know, there may be issues with everyone trying to submit their hardships at the last minute. So you just want to make sure that you get yours in promptly and in time.

And as far as whether or not the adjustments will stop under the E-Prescribing Incentive Program, the last scheduled payment adjustment is the 2014 payment adjustment. It is a reduction of 2 percent on your Part B FFS services or charges. And then after 2014 it ends. The E-Prescribing Incentive Program does not have any incentives authorized or payment adjustments, but in 2015, once that E-Prescribing Incentive Program adjustments stop, the PQRS payment adjustments kick in.

Janet Scott: OK.

Christine Estella: And those PQRS payment adjustments go on indefinitely. So, I mean, in e-prescribing it's good just to try to report the measure, because it is only one measure, whereas PQRS, you have multiple measures to report on.

Janet Scott: OK.

Christine Estella: And multiple different options and ways to report. So, at least with the E-Prescribing measure you're getting the handle of how to report and when you're – when you should be reporting ...

Janet Scott: OK.

Christine Estella: ...which would kind of help you with other measures in PQRS.

Janet Scott: OK, thank you very much.

Christine Estella: Sure.

Operator: And your next question comes from the line of Carrie Sovinsky.

Carrie Sovinsky: Yes, my question is in regards to the PQRS. We have a one-provider clinic with an audiologist whose NPI shows under the rendering spot on our claims. We were just wondering if we have to report for the audiologist?

Christine Estella: Yes.

Carrie Sovinsky: We do?

Christine Estella: Yes, an audiologist is an eligible professional under PQRS, and I think that was pretty recent, where that change was made, but yes.

Carrie Sovinsky: OK, and also, under Measure 130 for the medications list, we were just wondering – we're a little bit nervous about using this measure because sometimes patients come in and don't know their medication information at a 100 percent accurate. And we don't want to be penalized for putting in information incorrectly. Is that something we should be concerned about?

Kim Spalding Bush: No it's not. It's the intent obviously – this is Kim – it's the intent of the measure to obviously encourage the providers to try to get as much of a detailed history as possible from that patient. However, we also recognize the fact that sometimes a patient might be a poor historian. So we only ask that the provider try to the best of their ability to capture those medications.

Carrie Sovinsky: OK, because we let – at some point were being advised that we should possibly pull the prescription list from the pharmacy to make sure it was accurate. So that's not quite necessary?

Dan Green: No it's – it's just like anything else in the history—it's to the best of the patient's ability to convey it to the practitioner, and the best of the practitioner – to the best of the practitioner's ability to document it.

Carrie Sovinsky: OK.

Dan Green: If the patient doesn't tell the doctor that they're on an antibiotic that their primary care doc wrote for 3 days for a bladder infection last week, you know, we're not going to come audit and False Claims Act and all that other scary stuff for the thing that's omitted.

Kim Spalding Bush: Right, and that was Dr. Green that was just speaking. I don't want you to think my voice did a sudden change.

Carrie Sovinsky: No worries.
(Cross talk)

Dan Green: I'm glad she clarified that.

Carrie Sovinsky: And then, also, just referring back to the rendering audiologist, would we be able to report the same criteria for, like, the medication reconciliation for the audiologist that we report under the doctor? Because we report as a group on the billing under box 33.

Dan Green: So, again, just remember to clarify that group NPI. The group NPI can go on a – on the claim, as Christine said and Kim said, in (what was it?) on slide 6, but the individual rendering NPIs have to be unique.

If you put your group NPI where it's the rendering NPI, we can't pay an incentive because we won't know which doctor did or didn't perform that service.

Carrie Sovinsky: Absolutely. OK, thank you.

Dan Green: Thank you.

Operator: And your next question comes from the line of Jerusha Dass.

Jerusha Dass: Hi, this is Jerusha from Ocala Physicians. I have a quick question. The reporting for the incentive—should that be for the entire patient list or just a certain number of them?

Dan Green: So if you're doing a measures group, you only need to report on 20 patients. I would always encourage folks to report a few extras, just in case. But it's a minimum of 20 patients, 11 of whom – if you're using a registry, only 11 of them need be Medicare patients. You could have some non-Medicare patients that you send to the registry and they calculate the data. Obviously, if it's claims, they all have to be Medicare, because how else would you get in to us? When I say Medicare I'm talking Medicare Part B, you know, FFS – physician, or fee-for-service patients.

Now, if you're doing the individual measures, three individual measures, and you're using claims, then you have to report on 50 percent of the patients for whom the given measure applies. So if it's a diabetic measure – measures—say, the patient has to be between 18 and 75, has to have a diagnosis of diabetes, and has to be seen for a certain level E&M in the office.

So, you know, assuming – you'd have to report on 50 percent of the patients that meet those criteria if you're going to report, for example, that diabetes measure. Now, it so happens that that diabetic measure—and you have to look at each individual measure to see how they fall—but that particular diabetic measure only needs to be reported on each patient one time during the year. So, if Mrs. Jones comes back three times because she's – you know, to have her sugar checked, so to speak, you'd only have to report it on her one time during the year. Some measures are once per year, some are every visit, so it really just depends on which measures you're looking at.

Jerusha Dass: OK, and before the end of March do we have to report a few claims for payment adjustment or ...?

Dan Green: So are you talking about e-prescribing or ...?

Jerusha Dass: Oh, the payment adjustment is only for e-prescribe, is it?

Dan Green: No, payment adjustment in – we use the 2013 data; apply a payment adjustment in 2015.

Jerusha Dass: Oh, OK.

Dan Green: As Christine said before, you know, it's only one patient, one time that you need to report. However, we of course recommend more reporting than that. For one thing, we expect the criteria to avoid the adjustment will probably increase in future years. And so it's kind of good to get in the habit of reporting. As long as you have to report anyway, you know, better still to try to earn an incentive to make it, you know, that much more beneficial to you.

But you could technically report that last patient – that one patient, one time, you know, the end of December. As long as you, you know, do it then, you should be protected from the payment adjustment in 2015. But, again, we don't encourage folks to wait till the last minute. In case you have any questions or problems, it gives you an opportunity to give yourself a little bit of leeway from a safeguarding standpoint.

Jerusha Dass: Right. Is it – will there be a problem if you do your billing on a particular software, and you have for your EHR a different software? Will that kind of make any difference?

Dan Green: You know, it really depends on how your systems work together. I mean, we don't care how you – how you, you know, do your billing. Some people still use paper claims if they receive special permission. But the way you bill in that respect, you know – how you submit your bill shouldn't make a difference except if you are going to report via claims, obviously your software has to be able to ...

Jerusha Dass: Accommodate that.

Dan Green: Except those CPT-II and G-codes.

Jerusha Dass: Yes. OK, thank you so much.

Dan Green: Thank you.

Operator: And your next question comes from the line of Kim Sterk.

Kim Sterk: Hi, Kim Sterk from Lehigh Valley Health Network in Allentown, Pennsylvania. If I could go and ask Christine to repeat her announcement about Physician Compare, please, and what needed to be put in the subject line?

Christine Estella: Sure, so you're putting ODF in the subject line.

Kim Sterk: I'm sorry it was O, D as in David, S as in Sam?

Christine Estella: O as in Open, D as in Door, F as in Frank. Frank, yes.

Kim Sterk: Thank you.

Christine Estella: Did you need the e-mail as well?

Kim Sterk: I believe I have that.

Christine Estella: OK.

Kim Sterk: Physiciancompare@westat.com?

Christine Estella: Yes.

Kim Sterk: Thank you.

Operator: And your next question comes from the line of Lisa Hamilton.

Lisa Hamilton: Hi, I was calling in regards to the implementation guideline, or implementation guide, that is on the Web site. And it shows that there's a 2013 PQRS measure group specification manual, but when you click on the link, it does not take you to the group codes or the measure groups. And I was wondering if you could direct me where those are?

Dan Green: So you're trying to look at the measure specifications, is that correct?

Lisa Hamilton: Yes, the measure group specifications.

Dan Green: Just to be 100 percent clear here: So when you clicked on that – when you went on that page, you scrolled down to the bottom – towards the bottom where the Download sections are. Is that correct?

Lisa Hamilton: Correct.

Dan Green: And you double-clicked on one of the downloads that you wanted to ...?

Lisa Hamilton: Yes.

Dan Green: OK, because once you do that, it's a zip file, and then there's a couple files within that, and then you have to open them individually. But – but you couldn't even download the zip, is that what you're saying?

Lisa Hamilton: That's correct, and I also tried accessing it through the link on the – on the implementation guide. There's a link right there on the document that takes you to the site where – you know, where at the bottom it's – you know, where it says "Related Links." And it does – it just opens – it asks you if you want to accept the privacy and all that, and then it says "Error – page not found."

Kim Spalding Bush: We'll look into that, thank you very much.

Lisa Hamilton: OK, thanks.

Operator: And your next question comes from the line of Jennifer Luttman.

Jennifer Luttman: We were wondering if there was anywhere we can go online to check our status for the PQRS for, like, 2012?

Christine Estella: For the incentive? We – we don't have that information, or we're actually still analyzing the information we received, and – and actually, some registries or EHRs are still able to submit through the end of March.

Jennifer Luttman: OK.

Christine Estella: Yes, so that data won't be available until probably the fall.

Kim Spalding Bush: But we – if you reported through claims, we do have a dashboard that is available. So for that, you would need to go – it's – it's on the portal, the Physicians' and Other Practitioners' Portal. I don't know if you're familiar with that or not.

Jennifer Luttman: No, I'm not familiar with the portal.

Kim Spalding Bush: Let me see if we have it as one of our – one of our resources.

Jennifer Luttman: OK.

Kim Spalding Bush: I don't see it, but if you – if you go to our Web site, the cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS, on slide 33—if you go to our Web site, and you go under Reports and – I think it's analytics, analysis? Yes, Analysis. There should be a user guide there for – for the dashboard.

Jennifer Luttman: OK, for the portal. OK.

Kim Spalding Bush: And of course you can always call the QualityNet Help Desk as well, if you're – if you're having difficulty finding it, and they'll help you get there.

Jennifer Luttman: OK. Thank you.

Kim Spalding Bush: You're welcome.

Operator: And your next question comes from the line of Deanna Thayer.

Deanna Thayer: Hello, I wanted to know if the individual measures – do they all have to be Medicare, or does it – can it be commercial?

Dan Green: No, the individual measures would all need to be Medicare Part B patients.

Deanna Thayer: OK.

Dan Green: Even through a registry, but – but the measure groups, again, permit non-Medicare patients.

Deanna Thayer: OK. Well, thank you.

Operator: And your – your next question comes from the line of Shani Puckett.

Shani Puckett: Hi, this is Shani, and my question is, how do we determine which measures to report?

Christine Estella: Sure, so which measures you would report would depend on what type of practice you have, and this is for each individual eligible professional, whether or not you want to participate as a group or as an individual, and the types of reporting mechanisms you want to use.

If it's your first time reporting, again, you can use that – take a look at that implementation guide, the claims-based implementation guide, or you could also – the PQRS Web site has a How to Get Started section. I would use that section as well.

And if you, you know, if you're a little off, and you – you just want to know, you know, for your specific practice what measures to report, you could also contact the QualityNet Help Desk. They'll help you out with selecting measures. The number is on slide 35; it's 866-288-8912.

Shani Puckett: OK, I think that was the only question I had, so.

Christine Estella: OK, sure, good luck reporting, but yes, probably contacting the Help Desk would be most beneficial to you.

Shani Puckett: OK, thank you.

Christine Estella: Sure.

Operator: And your next question comes from the line of Ronda Scalise.

Ronda Scalise: Hello. Hi, this is Ronda. I just wanted to double-check: With the e-prescribing, if we attest for Meaningful Use, we don't get the money for e-prescribe. Is that correct?

Christine Estella: If you get the EHR incentive payment, then yes, that's correct. You can't get payment for both.

Ronda Scalise: Right, and then, do we still need to report the G8553?

Christine Estella: Yes, it only applies to the incentive payments of the payment adjustments. And Dr. Green was also going to mention, you know, it depends on whether you're participating about the incentive for the Medicaid or Medicare EHR Incentive Program.

Ronda Scalise: We did the Medicare.

Christine Estella: Yes, so then you wouldn't get the extra payment.

Ronda Scalise: Right, I just . . .

Christine Estella: Payment adjustments, you still need to report.

Ronda Scalise: But we still need to report the G8553 code?

Christine Estella: Right.

Ronda Scalise: OK, alright. That was my question. Thank you.

Christine Estella: Thanks.

Ronda Scalise: Bye-bye.

Charlie Eleftheriou: Operator, we have time for one more question.

Operator: OK, your final question will come from the line of Sonya Smith.

Sonya Smith: Hello?

Dan Green: Hi.

Christine Estella: Hi.

Sonya Smith: Hi. I just wanted – an earlier question, somebody was asking you about if you could use the incident-to claims for the e-prescribing. I just wanted to verify if you can use the incident claims also for the PQRS?

Dan Green: Yes, you can.

Sonya Smith: Yes, you can? OK. Alright. Thank you.

Dan Green: You're welcome.

Charlie Eleftheriou: Alright, if there's another call online we can take one more.

Operator: OK, then that question will come from the line of Kristi Knox.

Kristi Knox: Hi – hi, Kristi Knox, Gynecologic Oncology, West Michigan, and my question is, I know you don't know what all the exemptions are going to be, but the trouble we're running into is we obviously, doing gynecological oncology, see a very large portion of Medicaid/Medicare-eligible patients. But in our neck of the woods I'd say probably 85 percent of them are in Medicare HMOs—managed care plans. So is there going to be any – so we can't easily report that for PQRS, because we're not billing Medicare directly.

Dan Green: That's correct.

Kristi Knox: Is there going to be allowance made for that? Because we're doing all the work, and we're seeing all these Medicare patients. It's just that there's been successful commercial product to, you know, take over the Medicare billing. And how is – is CMS looking to adjust that issue, or look at it, or is it not an issue for you?

Dan Green: Well, a couple of things: First of all, hopefully you have one – at least one Medicare fee-for-service patient that you can report one measure to at least buy you some time and get out of the 2015 . . .

Kristi Knox: Oh, we do. I mean, that we can do.

Dan Green: OK. So, you know, if you have a lower volume, you could still report the three measures, albeit the incentive you would get would be, you know, adjusted because, you know, it's only going to be based on the charges – the covered charges for your Medicare fee-for-service patients.

Kristi Knox: Right.

Dan Green: You know, depending on how you're contracted with the Medicare Advantage programs—and it's a very rare exception, but in some instances they are

obligated—again, depending on what you – what your contract is—they would be obligated to also pay you an incentive if you earned an incentive through PQRS. But that’s the exception, not the rule for the ...

Kristi Knox: Right.

Dan Green: ...Medicare Advantage folks. We will – I don’t have an answer to the second part of your question—you know, what are you going to do in the future when it’s not one patient, one time? But it is something certainly that will be considered as the rules are drafted—the purposed rules, excuse me—are drafted for future years. So we thank you for bringing it up. And certainly, please feel free to, when the rule is posted, to send in your comment. Christine loves to read comments. And better yet, she likes to respond to them. But, no, seriously, we do invite the comments, and that would be certainly a very appropriate comment that we would want to address and consider in a rule.

Kristi Knox: Thank you.

Dan Green: Thank you.

Additional Information

Charlie Eleftheriou: Alright, unfortunately that’s all the time we have today for questions. If we did not get to your question, contact the Quality Support Help Desk at 866-288-8912, or e-mail qnetSupport@sdps.org. This information is available on slide 35 of today’s presentation.

Please note that while we may not be able to address every question, we’ll 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 information at a URL to evaluate your experience with today’s call. Evaluations are anonymous and strictly confidential. I should point out that all registrants for today’s call will receive a reminder e-mail from the CMS National Provider Call Resource Box within a couple of days regarding the opportunity to evaluate the call. You may disregard the 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 National Provider Calls Web pages on the CMS Web site within approximately 3 weeks.

Thank you, everyone, again, for participating, and have a nice day.

Operator: Thank you, and this does conclude today’s conference call. You may now disconnect.

-END-