

Centers for Medicare & Medicaid Services
Special Open Door Forum:
2010 Physician Quality Reporting Initiative & Electronic Prescribing
Incentive Program

With the American Society for Radiation Oncology (ASTRO) and the
American Society for Clinical Oncology (ASCO)

Tuesday, June 1, 2010
2pm-3:30pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will co-host a Special Open Door Forum on the 2010 Physician Quality Reporting Initiative (PQRI) Program with the American Society for Radiation Oncology (ASTRO) and the American Society for Clinical Oncology (ASCO).

The PQRI is voluntary quality reporting program that provides an incentive payment to identified individual eligible professionals (EPs), and beginning with the 2010 PQRI, group practices who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries.

The PQRI was first implemented in 2007 as a result of section 101 of the Tax Relief and Health Care Act of 2006 (TRHCA), and further expanded as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx Incentive Program is an incentive program for eligible professionals initially implemented in 2009 as a result of section 132(b) of the MIPPA. The eRx Incentive Program promotes the adoption and use of eRx systems by individual eligible professionals (and beginning with the 2010 eRx Incentive Program, group practices).

This Special ODF will be geared towards radiation oncology and oncology-specific topics related to participation in PQRI. Following the presentation, the lines will be opened to allow participants to ask questions of the ASTRO/ASCO presenters as well as CMS PQRI subject matter expert, Dr. Daniel Green.

PQRI information and educational products are available on the PQRI dedicated web page located at, <http://www.cms.gov/PQRI> , on the CMS website.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 76342214.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading on or around June 14, 2010.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.gov/OpenDoorForums/>.

Thank you for your interest in CMS Open Door Forums.

Audio file for this transcript:

<http://media.cms.hhs.gov/audio/PQRIASTROASCO060110.mp3>

Centers for Medicare & Medicaid Services
Special Open Door Forum: 2010 Physicians Quality Reporting Initiative &
eRx Initiative: American Society for Radiation Oncology (ASTRO) and the
American Society for Clinical Oncology (ASCO)

Moderator: Natalie Highsmith

June 1, 2010

2:00 p.m. ET

Operator: Good afternoon. My name is Sarah and I'll be the conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on 2010, Physicians Quality Reporting Initiative and Electronic Prescribing.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, please press star then the number one on your telephone keypad. If you'd like to withdraw your question, please press the pound key. Thank you, Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you Sarah and good day to everyone. And thank you for joining us for this Special Open Door Forum on 2010 PQRI. Today, this Special Open Door Forum will be geared towards radiation, oncology, and oncology-specific topics related to participation in PQRI.

As you all know, PQRI is a voluntary quality reporting program that provides an initiative payment to identify individual eligible professionals beginning with the 2010 PQRI practices who satisfactorily report data on quality measures.

Following the presentations today, we would have an Open Q&A. And you will have a chance to ask questions to a representative from

the American Society for Radiation Oncology and the American Society for Clinical Oncology and as well as Dr. Daniel Green here in our CMS office.

First, I'll go ahead and turn the call – let me make sure you all are aware that the materials are posted for today's call on our CMS Web site which is cms.gov. And the materials can be found on our PQRI Web site which is cms.gov/pqri. On the left hand side, you will see a link for CMS-sponsored calls and the presentation should be in the download section. And it is a zip file. Also, it is on the CMS open door forum website, cms.gov/opendoorforums.

And on the left hand side you will see a link for Physicians' Open Door Forum. And under the Downloads section, it is the second link in the Downloads, it will say presentation, or you can go to the website directly which is cms.gov/pqri/downloads, with an s /specialopendoorforum.zip. Because it is a zip file of three different presentations.

I will go ahead and turn the call over to Dr. Daniel Green who is the Medical Officer in our Office of Clinical Standards and Quality.

Daniel Green: Thank you Miss Highsmith. And welcome everybody to today's Open Door Forum. We appreciate your attendance and your interest in PQRI and E-Prescribing. I hope everyone had a safe and fun Memorial Day weekend.

As mentioned, the slides can be – can be found on our Web site. And I will refer to the slide numbers just so everybody can kind of keep track of where we are. We'll start on slide three. And during today's discussion, give you a brief background of how PQRI came to be, talk about PQRI reporting and implementing PQRI for those that are not currently participating.

On slide four, you can see that PQRI is a voluntary reporting program. It started in 2007 under the Tax Relief and Healthcare Act. In 2007, our reporting period started in July and concluded December 31st of

2007. So, it was a six-month reporting period. Over time, we've expanded the measures and the different reporting options. And the idea behind this is to make the PQRI reporting easier for eligible professionals who choose to participate in the program.

We're trying to collect quality data from – on the care that's provided to Medicare beneficiaries by eligible professionals. So, currently PQRI is a pay-for-reporting program. So, if you report in for your eligible patients, whether or not you did the quality action, we're not paying folks on performance calculations right now. We're paying them on the fact that they reported on at least 80 percent of the patients for whom a particular measure was eligible, or in the case of measures groups, that they reported on at least 30 patients.

In 2010, eligible professionals can earn an incentive payment for satisfactory reporting for three or more PQRI quality measures at 80 percent or a measures group. And if you are successful with your reporting, you are eligible to earn an incentive payment equal to 2 percent of all of your Medicare covered part B charges. So it's not just on the patients for whom you report the quality actions but it's actually all of your Medicare part B services that are covered services.

Looking on slide five, you can see a list of the eligible professionals who are qualified to participate in PQRI. And there's quite a list there including MD, DO, podiatrists, optometrist, oral surgeons, several different types of therapists, nurse practitioners, PAs, et cetera, social workers and there's more folks listed on that slide.

People that cannot participate in PQRI would include eligible professionals – I'm sorry, would include those professionals practicing at rural health centers, federally qualified health centers, independent labs, independent testing facilities. These are folks that were not defined as eligible professionals in the TRHCA legislation in 2006 which authorized PQRI or in MIPPA which was passed in 2008 and extended PQRI.

You can also see a list of eligible professionals by going to our website at www.cms.gov/pqri/downloads/eligibleprofessionals.pdf. And again, this appears on slide six if you missed that weblink.

Looking on slide seven, you can see that we're making an effort to try to move towards value based purchasing in the future. In 2007, the TRHCA legislation as I mentioned authorized PQRI. We had 74 measures; it was a claims-based reporting program only. With the passage of the MMSEA legislation later – in late 2007, that authorized us to use alternative measure – alternative methods of reporting which included registries.

And you can see on that slide, we added four measures groups in 2008, the same time we increased the number of measures from 74 to 119. In 2009 – late in 2009, the MIPPA legislation passed which brought in the E-Prescribing program which we'll briefly talk about at the end of this presentation. Also, we expanded the number of measures to 153; claims were still around as a method of reporting.

The measured groups increased to seven. And just for a quickie on measure groups, measure groups basically are clinically similar conditions that have a common denominator whereby an eligible professional can report on 30 distinct patients in that measures group that meet the denominator of the measure. And then they're deemed as having satisfactorily reported PQRI.

If they don't get all 30 patients, they have to report on at least 80 percent for whom the measures group applies. In 2009, we continued registry reporting. And in fact we expanded the number of registries who were reporting quality to us. And we also began EHR testing.

Currently, we have a 175 individual measures, we're still using claims. There are now 13 measure groups; no longer does an eligible professional have to report 30 consecutive patients which was the requirement through 2009. Now for measures group again it's just any 30 patients that meet the denominator that we're seeing throughout the year.

Registry reporting is continued and we have even – we're currently qualifying additional registries. EHR Testing, if you're using one of the seven CMS PQRI qualified EHRs which is listed in our website, if you're using one of those vendors and one of their products with specific version that's listed there, there are 10 measures that can be reported electronically plus the E-Prescribing measure.

We still have the E-Prescribing program. And in 2010 we also have something called GPRO or group practice reporting option which enables practices with more than 200 eligible professionals to report their measures as a group. For 2011 PQRI in the Healthcare Reform Act, PQRI was authorized for additional time period. It had been authorized previously but it's now funded. So, for 2011 eligible professionals who successfully participate in PQRI will receive a 1 percent incentive payment of their Medicare covered part B charges.

And in the future, meaning in 2015 as I believe, there actually starts to be a penalty for folks that do not participate in PQRI.

So, let's turn to slide eight, we'll talk about quality measures. A quality measure is a tool basically that provided an indication of performance in a healthcare setting and it's based on specific evidence that's developed by clinical experts and if we'll break down a measure in slide nine, you can see that the numerator, it's like a fraction. The numerator basically is the clinical action required for performance.

So, patient had a heart attack and I gave him an aspirin within an hour of arrival to the emergency room. So, that would be a clinical quality action that you would – that you could report again if the patient met the denominator of you know has the right CPT code and the right ICD-9 code, so, the right service as well as the right diagnosis. If you did the quality action you would report that you gave them the aspirin.

Now, you may come to – it may come to pass that that same patient comes here with a heart attack, but you don't give them an aspirin because they have a severe aspirin allergy that could cause them to

anaphylact if you give them the aspirin. So, there's – for many measures, there are exclusions. So, in this case it would be a medical exclusion why you didn't treat that patient for the recommended quality action.

In any case, when you take the overall numerator so that the number of times the clinical action is met and you divide it by the number of eligible cases, so that the number of cases where the action could be performed, you get the – you get a performance rate.

Looking at the reporting rate, we talked about where the clinical action was met and then you add in the performance exclusion just like the person who was allergic to aspirin and also the times that the performance was not met. So, I didn't give them the aspirin, they weren't allergic to – they weren't allergic to aspirin and I'm not saying why I didn't give them the aspirin. So you know there are all these different possible scenarios.

So you add up all the patients who fall into those particular buckets and you divide it by the number of patients that came in with and had the service performed and had the diagnosis and then you come up with the reporting rate. And as I mentioned earlier, PQRI is currently a pay-for-reporting program.

Moving to slide 10, you see that some measures have a performance time frame related to the clinical action that may be distinct from the reporting frequency. So, for instance, you may have to perform a particular test or what have you for quality action within a 12-month period or annually. The most recent result generally is from one that we're looking for and it may not have been reported during the – or performed during the reporting period. Our PQRI measure number one has to do with hemoglobin A1C which, as you all know, is a lab test.

So, this particular measure is looking to see where the patient, where their value was of their hemoglobin A1c and you can look from the date of service that the patient is in your office all the way going back

up to 12 months. So, if they had a hemoglobin A1C six months earlier and it's a level 6.9, you would report the code that it's less than seven. If you had a hemoglobin A1c that was two years earlier and that was the only one that, that was the most recent one on the chart, you would not have met the measure because the patient would have not had a hemoglobin A1c within 12 months, so that patient would actually be excluded because they wouldn't have – they wouldn't have anything within the 12-month period to report.

OK, so let's talk briefly on slide number – if the pages will come unstuck – slide number 11. We're talking about reporting frequency, so sometimes it's for a requirement for each patient seen during the reporting period to report only one time only. So, the hemoglobin A1c is one such measure where you only have to report it one time per reporting period for each eligible professional.

Sometimes it's once for each procedure performed. So, you can imagine if you're giving surgery and there's a measure in there that you gave – you ordered prophylactic antibiotics to be given within an hour of your skin incision, obviously if you do a gall bladder on a patient last month and you do an appendectomy on them three months from now, you're going to need to report it each time the patient has a qualifying procedure that appears in the denominator. So, those would be the examples of procedure type measures.

Some will report each acute episode, the aspirin and the heart attack I mentioned earlier, that would be an example that – and then there's other measures that require the measure to be reported at each visit such as certain – there's a medication measure, I believe it's Measure 130, and it's supposed to be reported each time the patient is seen.

So, moving on to slide 12, I mentioned earlier what measures groups are and it's – one thing I didn't mention is, measure groups contain four or more measures. So, while folks only have to report on 30 eligible patients, to sat-, to meet the requirement, they do have to

report on more than just the three measures that would be required if they were reporting individual measures.

So, it's important to know, folks, that measured group specifications are not the same as those for the individual measures. You have to look at the special manual for measures groups. So in other words, all the codes that (inaudible) appear, of the denominator of the individual measures don't necessarily appear in the measures groups denominator. And the reason behind that is that we had to harmonize those measure denominators so that we could get at least four measures or more that an eligible professional could report for a given patient. In other words, if the denominators were different, a patient might fall into, let's say, the first and third measures in the measured group, but not the second and fourth. So, they had to be harmonized so they fall into at least four measures in the measured group. So, please do check if you're reporting a measures group, please do check that particular manual.

Moving on to slide 13, as we mentioned there are 13 – yes, there are 13 measured groups, diabetes, chronic kidney disease, preventive care, and the preventive care one's a little tricky because not only do you have to make sure that the patients have the proper age, certain tests are recommended within a particular age band, but also you need to check on the gender of the patient to ensure that he or she is eligible for a given measure in that group.

We have coronary artery bypass graft measured group. This measures group is only reportable by – through our registry. We have rheumatoid arthritis, perioperative care, we have a back pain measures group and you can only report the back pain measures as a group. You can't report them as individual measures which is a little bit different than some of our other measures.

We have CAD or coronary artery disease measured group which is registry only. We have heart failure which is also registry only measured group. We have hepatitis B, HIV AIDS which is also

registry only. Community acquired pneumonia, Ischemic Vascular disease measured group as well.

Moving on to slide 15, how, you know, we recommend for folks getting started, they go on our website, it's a pretty thorough website, and it's cms.hhs.gov/pqri. You might want to look at the measures and codes or the educational resources, the toolkit web pages, some gathered information from other sources such as your Specialty Society and the folks that are kind enough to co-host this meeting with us today can certainly give you additional information.

You can look at the AMA or state medical association for additional information. Please be aware however that the CMS website does contain the authoritative measured codes for the measures you may select, and any discrepancy between one of the outside groups and our website – our website would have to trump that at least for specification purposes. You'd want to select the individual measures or measures group that you intend to report. And please be aware it's not too late start. There is a six-month for reporting option through claims this year.

So, you can start now and – or July 1st, and still you know get an incentive payment, if you're successful for a half year of your charges, again, if it's a half year reporting period, because the incentive payment matches the particular reporting period. You want to determine which reporting method or reporting option: Do you want to use claims? Do you want to use registry? Do you want to use EHR, which one best fits your practice.

Again, EHR-base reporting is only available for reporting individual measures and with that, there's only 10 that are electronically specified. So you want to check that if you were thinking about doing EHR-based reporting. And as I mentioned earlier, you select a reporting period, 12 months or 6 months. The six months reporting period is not available for EHR-based reporting in 2010.

Some registries allow you to enter data after the fact, so even though we're you know, starting our six months of the 2010, some folks – some registries will allow you to enter data from earlier in the year, from your chart. So the year-long reporting period is not definitely out either, if you want to choose to go to registry method.

All right, on slide 16, in selecting the measures, consider the practice characteristics of the clinical conditions you usually treat, the types of care you usually provided, is it chronic, is it acute, is it preventive? The setting for the care is usually deliberate. Are you a surgeon, or are you – do you do most of your office, emergency room, and then also what your goals are for quality improvement in 2010.

Do you want to review the 2010 PQRI measures list? And again, this will help you determine which measures apply or which patients are seen most frequently in the Medicare population for you. It will also tell you which ones are one-time reporting per patient for a reporting period as well with episodes or procedures. So it'll give you more definition as to how frequently the measures need to report – be reported, excuse me.

And then again, you want to select the measures on which you intend to report, so at least one measured group for at least three individual measures if you have three or more measures which apply. And if you only feel you have one or two that apply, you would be subject to a validation test where we look to see if there are other clinical similar conditions, and so in other words, if you reported only the two diabetes measures, we'd want to know why you didn't report the third one, because there's three of them that are very similar, for instance.

But if you're a pathologist and you only report on the two pathology measures, well, there are only two pathology measures. And if you don't bill the other one, and the other measures apply to the practice, then obviously you'd be filing just the two.

So again, this MAV we call it, Measure Applicability Validation, is available on our website, it discusses situations where you would not

have to report three measures, but they're rather few and infrequent. And so you want to try to remember three measures or more if possible.

Moving to slide 17. Reviewing study measures specifications for selected measures or measures group, groups, so you make sure you understand the reporting instructions, how to code them, the frequency of reporting. There's a measure specifications manual for claims and registry and there's release notes that accompany them. And on these slides you can see our website. Our website is listed with these references.

There's the 2010 EHR measures specs, the manual and release notes. And as for the individual measures that we were talking about, they can be reported via, excuse me, a PQRI-qualified EHR. There's also the 2010 measured group specifications manual and release notes. And again, the website information is listed on slide 17.

So, you want to select a reporting method, if you want to use claims, if you want to use one of our qualified registries, or our qualified EHR, and again, the list of qualified registries and EHRs are available also on our PQRI website. Notice the pattern here, folks. So moving to slide 19, there's a nice colored diagram which shows what happens, at least in the claims process.

The visit's documented by you guys in the medical records, you give an encounter form to the patient or to your billing person. They code and bill it. They send it in to their Carrier/MAC. Carrier/MAC should report back an N365 for the quality data code which is a CPT 2 code or a G-code.

So the N365 that comes back from your Carrier/MAC says we're denying this part of the claim for basically this quality data code because there are no payments associated with quality data codes except if you are in a bonus.

So, we're denying this line, if you will, on the one hand. On the other hand, we did receive the code. So you want to look for the N365 because it's a nice way to ensure if the code didn't make it into your Carrier/MAC and subsequently will be sent to our national claims history file.

The analysis contractor gets the data from the national claims history file. They analyze the data and they produce a confidential feedback report.

This information, or they then notify the Carrier/MAC that Dr. Jones is eligible for incentive payments and they notify the amount and the Carrier/MAC then ultimately issues the incentive payment. So that's how the process works. If you're going to do claim submission, you want to assemble an implementation team. That sounds rather dramatic. You basically just want to make sure your billing/coder is aware that you're going to participate. And they may need to ask questions of the practice billing software and clearing house to make sure that all the codes can be captured and passed through to the Carrier/MAC.

So again, alert your staff that you will be doing these measures, so they can remind you, they can flag your charts if the patient meets the denominator of a particular measure that you're going to report on.

On slide 21, you want to develop a process. So all concurrent data collection for all eligible claims for PQRI, you want to make sure that all the quality data codes are correctly identified and submitted. And again, regularly review your remittance advice, or have your billing person do so to ensure the receipt of that N365 remark code for each quality data code that you submit.

Some brief principles about claims-based reporting, quality data codes which supply the numerator, we prefer that they be reported on the same claim, but even if they're not reported exactly on the same claim, but it's a continuation of a claim, we will rejoin the claim. But you have to have on the – in other words, if you see Mrs. Smith today and

you have too many line items for one particular visit, so you have to carry over on to a second claim, make sure there's at least a one penny charge on that second claim or the total claim will be denied.

You can't submit a zero charge on the –part two, if you will, of a claim. So that's very important. We will attach for the same patient, same data service by the same EP. We will reattach those claims, if you will, even if your quality data codes and/or procedure codes run over to a second claim. But it is important to have at least a one-penny charge if the second claim only contains quality data codes.

So again, same beneficiary, same date of service for the same eligible professional which we define as a TIN NPI, tax ID number and NPI number. All diagnoses reported on the base claim will be included in our analysis. This is critical. You cannot re-submit claims solely for the purpose of adding quality data codes.

So if you have to resubmit a claim because you know, Medicare said hey, this doesn't seem like it be should a level five service. You know, you want to look at it. You look at it and you decide it's a level four, so you're resubmitting the whole claim for you know, another billing or – error, yes, you can definitely append the quality data code if it were – if it were not previously attached. However, you cannot resubmit claims solely for the purpose of adding quality data codes; we get that question almost every day, it seems like.

Quality data codes must be submitted with line item charge of zero at the time the associated covered service was performed. However, again, as I mentioned, if your system does not allow a zero line item charge, you can insert a penny there. You just can't leave the charge field blank.

So moving on to slide 23, quality data code line items will be denied for payment as we talked about. And we talked about the remittance advice and looking for the entry 65. Entry 65 specifically says, "This procedure code is not payable. It is for reporting information purposes only."

So it doesn't indicate that the quality data code that you submitted for a given measure is necessarily accurate. It's just says that we received the quality data code. So you want to make sure that you code – your code is accurate for the measure you intend to report.

On slide 24, if you're looking for more guidance on claims-based measure reporting; please refer to our 2010 PQRI implementation guide. Or getting started with 2010 PQR reporting in measured groups. And again, the websites are listed on slide number 24.

Moving on to slide 25, some common errors that we have discovered; eligible claims submitted without quality data codes, so you want to watch the denominator to make sure you capture all folks for whom you should be reporting. Including Medicare as a secondary payer, that would be a place where you'd want to make sure that you reported. And sometimes, the primary payer will strip off quality data code, so whereas normally ABC Insurance Company will send, forward the claims to Medicare after they've processed it for the secondary payment, it may be that your billing folks need to actually send in a claim with the quality data code to Medicare even when it's secondary.

Eligible claims submitted as quality data code only so there's no denominator information on the claim, that's a problem. Again, your billing software could be splitting the claim.

There's ineligible claims with quality data codes where the measure of the diagnosis is incorrect or insufficient. Eligible claim with insufficient quality data code – eligible claims denied by your Carrier/MAC and you send it in again but without the quality data code. Eligible claims paid partially by primary payer, again, submitted to Medicare without the quality data code.

So these are some of the common errors that we've seen, again, looking on slide 26, you could see some additional errors, including missing reporting quality data on eligible claims. Reporting quality

data on a claim with a non-specific code when the measure required a surgical procedure code or a consult code. Reporting quality data code on a claim with a diagnosis CPT I service or not listed in the denominator for the measure.

Reporting one QDC when the measure requires two reporting; reporting one diagnosis when two diagnoses should be reported, and there are three other common errors that appear on 26. And I'll leave you guys to read rather than hear me babble on here.

If you report a quality data code on a claim for a service that is not covered by Medicare or was denied by the carrier, that's another example of a reporting error where the individual rendering NPI was not listed on the claim. If there's no NPI on the claim, then that claim is not included in the PQRI analysis.

So I'm going to spend just the last two or three minutes before we wrap up off talking about registry submission and EHR submission.

I'm looking at slide 28, a registry captures and stores clinically related data submitted to the registry by the eligible professional. The registry then will submit information to us with the permission of the eligible professional on either individual measures or measures group on behalf of the eligible professional.

We select the – we being CMS select the qualified registries annually. And basically, anybody can self-nominate. There's criteria that we list in our proposed physician fee schedule rule here that's subsequently finalized in November, but it comes out generally July 1st. And then the registry has to self-nominate and go through a vetting process too, so we can have at least some degree of certainty to say we'll likely be successful at submitting the data. But CMS does not guarantee by going through the vetting that registry will definitely be successful.

So registry is to provide us with eligible professionals to calculate a reporting performance rate at the end of the reporting period.

And we have particularly – a particular specified format that we require registry to send its data to us in XML specific non-specific for PQRI. Looking at slide 29, as I mentioned, there are seven qualified EHR vendors for PQRI currently. And that list is on our Web site at cms.hhs.gov/pqri/downloads/qualifiedehrvendors/rvsd01042010final.pdf. So again, it's on our website if you can't, if you, if you miss that link.

As I mentioned, there are only 10 measures. Some of these are primary care. Some are related to diabetes care. We are looking to possibly expand it, but as our first foray into EHR data submission, there's a limited number of measures. I'm sorry, there are a limited number of measures. My grammar teacher's probably turning over in her grave.

So if you are going to report using EHRs, make sure you do so using a qualified EHR. The eligible professionals would submit raw clinical data to CMS and we would do the measured calculation. Before we move on to the last two slides, I just want to briefly mention the electronic prescribing program exchange for 2010 in that – there's only one G-code to code report, so if you have a qualified E-prescribing program, so basically, there are four qualifications that a new prescribing program must have. And that's available on our e-prescribing website. But briefly, it has to generate and transmit the prescription electronically, check for drug-drug interactions, look for lower cost alternatives, using formulary information and be able to generate a – sorry – a medication list among other, and also warnings and drug interaction information with the eligible professional. And there's a little bit elaborate presentation about it on our website.

But if you're using a qualified system, you have to report that you did at least 25 prescriptions. Each patient visit would count that appears in the denominator. So, again, your typical office visit would count as one. And you have to generate at least one prescription 25 unique times during a year.

So if Mrs. Jones comes in today and you send one prescription electronically and give her three handwrittens for whatever reason, that would count as one of your 25. Even if the same patient comes in next week and you give her another prescription electronically, that counts as the second one, you know. So again, we only are requiring folks to report – if they have a qualified system and that they used it to generate a unique prescription 25 times during the year for one of the services that appears the denominator.

If you write five prescriptions electronically for Mrs. Jones on day 1, that doesn't count as five times. It's only reportable as one time. So no longer do you have to do the 50 percent of your eligible instances as was required in 2009. So you can get a 2 percent incentive in 2010 and it's easy – if you have even a moderate amount of Medicare patients or a small amount and you have a qualified system you could knock out the E-prescribing requirement in a month or less.

Additional resources on slide 30, our PQR website as we've been talking about. We have tip sheets, we have fact sheets, frequently asked questions, we have monthly national provider calls, and we do publicize when the dates are for these things. You can sign up for listservs.

And then finally on slide 31, if you have additional questions, you can contact our QualityNet Help Desk. And they're open from 7 am to 7 pm Central Time, Monday through Friday, and their phone number is 866-288-8912 or you can e-mail them at qnetsupport@sdps.org. And then there's two other websites – weblinks on slide 31 that you can check out if you need additional information.

So sorry to rush through all that. It's a lot of material and I appreciate your time and attention. I'll turn it back to Ms. Highsmith.

Natalie Highsmith: OK. Thank you Dr. Green.

Our next speaker is Dr. Michael Neuss. He is the chairperson of the American Society for Clinical Oncology Clinical Practice Committee.

And we'll go ahead and turn the call over to him.

Michael Neuss: Thanks very much Ms. Highsmith and thanks Dr. Green for your presentation which covers a lot of material.

I won't reiterate and thanks also to Julia Tompkins and Karen Haggerty who are on the line as ASCO staff who put together this slide presentation, which I will be going through now.

As an intro – I don't have to say much as an introduction because Dr. Green has covered the program relatively thoroughly. He did not get into the specifics and the specifics for oncologists.

If you look at my slide number two, this starts with the measures which are relevant to oncology in the current year's measures set as was discussed previously, which is a large data set.

And for most of these measures, if not all of the ones specific to oncology, these are measures that are generally reported once per reporting period and not on every visit, although I can't attest to that because I haven't gone through all of them. But most of these are just a one time per data period reporting.

As you'll see, some of these have a hematologic bent again on slide two. They refer to things that most physicians, I suspect, would hope to do nearly universally, cytogenetic testing on a bone marrow in a patient with acute leukemia or a myelodysplastic, measure 67; giving multiple myeloma patients bisphosphonates as appropriate, measure 69, doing flow cytometry and CLL, et cetera.

I'm not going to go through all of these, except to say that appropriate use of chemotherapy has been studied in a variety of different venues and has a very high concordance. So, it's not something you're going to be embarrassed by reporting, even though at this moment in time the payment is for reporting only not for reporting at a threshold measure.

Slide number three lists other measures of relevance to oncology, regarding colorectal cancer patients and having the appropriate number of lymph nodes reported; prostate cancer patients not getting bone scans when they shouldn't; advising smokers to quit smoking, et cetera.

Slide four has a further group of measures and does have a one interesting registry group – in melanoma patients – that can be reported as a registry group and in a large melanoma practice that can be very helpful because that only requires reporting on 30 patients instead of 80 percent of all patients. We'll go through that again.

Now, if we move on to slide number five, a practice – in order to get paid – and I guess this is – at this stage, the major purpose for this, since you're created on appropriate level of achievement, is to report on patients with an appropriate diagnosis that would be the denominator. And that is defined by billing codes within the PQR measures and then report by these special codes the appropriate intervention or behavior relevant to that diagnosis.

As was said by Dr. Green, this can be reported through claims. It can be reported through an approved registry and, in rare instance, not often done in oncology, can be reported through an approved electronic health record and those defined 10 measures within the EHR.

As was said, and this is the trick, to report on 80 percent of all denominator codes for at least three measures if there are three measures relevant to almost every oncologist, if you report through a registry, it's simpler because it's not just Medicare patients. It's any 30 consecutive patients and with an HER it's 100 percent of patients, though one oncology practice that did successfully complete PQRI last year did it via the electronic health records.

If we move on to slide number six, we're going to talk in a little detail about how this process is completed for a particular patient that we'll talk about, measure number 71, in general, which is the appropriate

administration of hormonal therapy for stage 1c to 3c, hormone receptor positive breast cancer.

I think that it's undeniable that this is a quality measure. This is one of the Joint National Comprehensive Cancer Center Network and American Society for Clinical Oncology endorsed quality measures.

And the trick in completing this process is identifying the patients correctly and the trick with doctors if those of you who are practice administrators or otherwise non-physicians may be willing to admit, I think the term “herding cats” is overly optimistic in deciding physician behavior. And I think doctors don't like doing one additional thing that doesn't have clear relevance to patient care.

And there is some pushback particularly if the doctors aren't given, led to exactly where they have to check a box to fill in the blank. So it is critical to identify the patient is eligible for this measure for two reasons. One, it lowers the irritation of the physician and perhaps more importantly, why do it if you can't do it successfully.

And successful completion requires, first, identification of the patient which in this case is defined as only female breast cancer patients who are 18 years of age or greater who have these included diagnosis codes, including the follow-up diagnosis for breast cancer, the V10.3 code for patients who has completed their treatment and are being seen on follow-up; and who have the appropriate CPT Service code billed as well.

This is how the denominator or the eligible population from which the 80 percent number is defined is constructed. In slide six – excuse me – in slide – now my computer is frozen.

In slide seven, we want to look, again, this measure will be reported once per reported period and you have to identify, the physician has to identify the appropriate code for the numerator in this circumstance and that is if the patient is included as the denominator if they're

included in the analysis set, were they given to Tamoxifen or Aromatase Inhibitor as appropriately. That's one choice.

If you move to slide eight, it talks about the codes of relevance to this where you have to certify that the patient was within the appropriate stage of cancer, that they were ER and PR positive, and that they received Tamoxifen or an AI.

Option two, which can be reported again as a successful reporting of the numerator of the action taken that the Tamoxifen or AI was not prescribed for medical patient or system reasons, most codes allow a choice like this.

And in slide 10, we see more of the detail of option 10 that – excuse me – of measure 71 which is, you can say you didn't report it because the patient was of another stage or did not have ER or PR positive breast cancer. That's seen better – that's seen completely on slide 11 where we also mention another exclusion—the patient has metastatic disease, not early breast cancer receiving atrovant therapy.

And in that choice, you would pick option four, that is you're submitting a breast cancer code and a visit for a breast cancer and the patient is not eligible for the code because they're ER or PR negative.

And if we move to slide 13, the final option, the patient is not eligible for the code because the ER/PR is not documented or the cancer stage is not documented. Obviously, one would hope that one didn't have to use this very often as knowing that ER/PR is a very routine part of care as is documentation of the cancer stage.

If you move on to slide 14, the honest disclosure is that most practices have found it very difficult to successfully complete PQRI reporting. The first and seemingly easiest to surmount hurdle is identifying the eligible patient population. My billing staff asked me approximately five times for PQRI information on a patient who didn't have breast cancer because somewhere in the past the code had been identified, the 174.X code has been identified in her chart.

And once it was in our system, we didn't know how to get it out of the system, and the PQRI reporting tickler brought up that patient every time because of the erroneous diagnosis. So that's a problem in two ways. And it's a problem because it probably makes my denominator wrong in the future reporting, and it's a problem because my system won't let me take that erroneous code out so they keep asking me for information.

It is also difficult to report on 80 percent of the population especially with some of these common diagnoses. Some practices have felt that it is simply not worth the 2 percent bonus payment particularly if this does not include expensive things like chemotherapy. And they feel that the time intensity versus return value makes this a poor investment of time.

And one of these most vexing problems despite the fact that Dr. Green mentioned in his slide number 19 that it was a critical step to make sure you were getting feedback that the claim had been submitted, other than that that refusal of payment based on the fact that this isn't paid until later, there's no immediate feedback, and it's very hard to know how you're doing until the process is long over, and that's frustrating.

On the other hand, if we move on to slide 15, "Why participate?" Obviously, 2 percent that you wouldn't get otherwise is 2 percent that should come to near the bottom line except for the expense of setting of the software to identify the patients early on. It seems that The Patient Protection and Affordable Care Act., the Health Reform Act is going to ask for – is going to cause us to live in a world where there will be more quality reporting and not less, and this does give some entree into the system that is relatively painless.

There, I'm sure, are instances where physicians have realized that they don't have the information that's been requested on a particular patient and may have done something important and beneficial to the patient. And certainly, getting feedback on how you're doing is a good thing.

It does seem to be the future of care. The reporting periods are important to understand and know. And the current reporting period is July 1st to December 21st although Dr. Green did talk about some ways to look back and do some reporting and registry reporting, although there are no oncology areas, would be helpful.

Slide 18, give some helpful tips from practices which is first of all don't look at your highest frequency patients, look for one where it will be easy to make the 80 percent because there are fewer patients. Try reporting on more than three measures so you can get 80 percent of three measures.

Use the tools that are available for CMS which have been amply described in this call by Dr. Green, the AMA and ASCO, and get some buy-in from the doctors by creating a system within the practice; at the end of the reported period look back on your practice and see how you're doing and re-evaluate it and decide if it was worth doing.

Slide 21, we are hoping to get some registry reporting options available. Certainly, there is breast cancer, colon cancer, lung cancer would offer the opportunity for registry. And Consortium for Practice Improvement has been proposing measured groupings to CMS and hopefully we will get that through.

Finally, on slide 22, let me just say, this is like raising children. The gratification is deferred. Success takes a while to see, but more and more practices are reporting that they're getting paid and that they're enjoying less disruption of work by doing this process. It is the standard of care, most of these measures in the QOPI practices that have been measured by ASCO are being achieved at near 100 percent.

And though the value relative to the time spent may be small and few at first, you've all noticed that in the future if you don't report, there may be penalties and the future is now. I'm sorry if I went over a couple of minutes. And I'll stop now.

Natalie Highsmith: OK, thank you Dr. Neuss. Now, we will hear from Terri Henning who is the Chief Operating Officer in the Toledo Radiation Oncology Incorporated. And we will hear from her.

Terri Henning: Thank you Ms. Highsmith. As has been said, I have this in a little bit of a different perspective and that I have actually implemented the program through the physician route as well as the staff route. And I'd like to thank the ASTRO staff for their assistance in putting this together and also taking this call to be a little bit of a hands-on approach from someone who's done it.

My role as Chief Operating Officer has been to guide the physicians and the staff through the process each year we have built and hopefully getting successful each time we do it. As a background, TRO is a 16-physician member practice and we also employ a PA.

Slide three is just an overview of the discussion and then going into slide 4, these are the specific radiation oncology measures for 2010. And our group is reporting on five of these measures. To give an example of a specific, Dr. Neuss had given number 71 breast. I'm going to do measure 102 for prostate cancer. This measure is reported per episode. And we have been claim-based since we began doing these.

This one is relatively simple in terms of diagnosis code because it is ICD-9 185 which is the prostate malignant code. And this has to do with the avoidance of an overuse of (swollen skin) for staging low-risk prostate cancer patients.

There are reporting options and the simplest way to begin this is definitely to utilize the tools that are on the CMS website, AMA ASTRO also has the actual measure criteria written. The very concise sheet that gives the information that's reporting options goes through option one, two, three, four and five as to how you would do these given the status of, if they were a low-risk prostate patient, if they did have a bone scan that had been performed or if they had not.

And then the reasons of why perhaps a bone scan would have been done. On page eight, the reporting option three that actually talks about the medical reasons of why this may have been done.

And that such as a documentation of pain or there was – this was for salvage therapy or there was another medical reason, these each have the CPT-2 code associated with them. Then if it's a system reason of why a bone scan was performed, that could be that another physician other than the reporting physician has actually ordered the bone scan, that is another CPT-2 code that gets put out.

The AMA has developed a sheet that is kind of, I guess it could be considered a direction sheet to the physicians or to the staff. And that is a varied list of yes-no's and it also has the CPT-2 codes on that. We chose as a practice to develop our own internal sheet to make it as simplified to the physician as possible.

As Dr. Neuss said, many things go on in a day and to give one more thing to the physicians can be overwhelming for everyone. So we made this for measure 102 and 105, a simple yes-no circle sheet. The physician completes this at the time of the consultation or the new patient visit.

And the staff then completes the rest of the sheet. So this is completed by the physician along with the documentation that is sent to our billing office. And then we submit that through the claims base as I said.

My role as an administrator has been to basically oversee this, and as you can imagine, we have 16 oncologists. They treat in nine different sites. And our practice sites include outpatient hospitals, free-standing and academic. We have a billing staff of five people, and three compliance auditors and myself that are involved in this.

And we chose to be involved from the beginning in July 2007 and ASTRO's quality task force was involved in developing the measures for PQRI. And our goal was to be part of a quality process. It was a

voluntary program. And it would eventually be mandated and so we believed it would be important to understand and develop internal processes as this program grew.

In 2007, we reported on two measures. We did log on and get our feedback report as Dr. Green has stated the importance of doing that. That occurred in fall of 2008. We did not receive a bonus. The login process was cumbersome. We are improving in that and I believe that the whole process is improving. In 2008, we decided that we would report on six measures and discovered that that was really overly ambitious and ended up reporting on four measures that year.

We did log on, get the report. We did receive a bonus for 2008. And as there's no appeal process, it really was a matter kind of living and learning along with everyone else.

In 2009, we reported on four measures. They were different than the ones we've done at 2008. And the feedback report will be available in late summer or fall of 2010. And this year, we are reporting on five measures.

That is probably one of the more difficult – I think Dr. Neuss' explanation of delayed gratification is a good example. You begin the process without really knowing what you have done correctly and what you have not. We do look at the claims reports that come back. We ensure that there is the N365 report code on so that it has not been stripped somewhere along through the process.

It is a significant investment of manpower hours. We have monthly physician business meetings in which usually PQRI some update report or some explanation that's being given. We have monthly staff meeting. We had a system upgrade that we normally would do, our hardware and software are – did allow all of the CPT-2 codes. We did have any problems with seals that we did not enough or we could not do that. Full integration has actually been a new event every year that we've done this.

On slide 14, what needs to be done before reporting period begins, I think everyone has – the other two speakers had covered that. You really do need to do your homework. You need to do the process evaluation of how this works into your process, into your program, how it works into your staff, identify your key people.

Who the decision-making is; how many you're going to report on; what can you accurately do; and then follow that path. There's constant education, constant follow-up. I have a wonderful business manager and billing manager who knows the system well. She has put multiple pop-ups into the system and a flagging system.

So that when we encounter the diagnosis codes that go along with the reportable CPTs, the input people, the billers, cannot input the codes without having those CPT-2 codes on them. So that, it's kind of eliminated or modifying, not having the modifiers put on.

The communication routes needs to travel both ways and we've discovered this and it is getting easier now that we're in our fourth year. The routes need to travel up to the physicians as well as the physicians communicating back through the staff. And we have done that successfully.

The physicians are very, I guess, in tune by this time of what needs to be done. Their documentation has improved in detail. Information was always there. But I think in the whole process of making it a simplified quality process, those dictations are more concise.

After the reporting period is done on slide 16, we evaluate this every year. And in the end of the process year, even though we don't have a report, we do at least quarterly review what is happening. If we get a bonus, we are excited. We've had one.

But that is not the reason that we opted to enter into the PQRI program. We were well aware that the cost of doing this in terms of dollars would not balance with what we could be recovering. But it

was, as I said, a whole basis of being part of a quality program and moving forward to the future.

Probably from the practice administrator – one of the hardest issues is the timing of the release of the measures at the end of the year and all of the documents that are prepared and ready on the website, and then the implementation happening on January 1st.

That is something that tends to be of little bit of a scramble for us in the practice as large as it is. I think that the whole basis of the lessons learned from everyone have been working together for a quality product. Communication throughout the group has improved immensely.

We've had lots of networking opportunities through professional societies. We use the educational tools. We'd listened to the CMS PRQI conferences as a group in rotating those people in the staff. And I think patients on slide 17, the definition says it all. Can't say that we have done it or endured without complaints, but we have persevered and we're proud of that fact.

Slide 18 has the ASTRO website, CMS and also AMA that we have used.

And also on slide 19, it lists the PQRI support that's available in ASTRO and also the staff member, Sheila, who has been very helpful. Thank you.

Natalie Highsmith: Thanks. Thank you, Terri. OK. We're ready to move into our open Q&A portion of the call. And Sarah, if you can just remind folks on how to enter the queue to ask their question. And everyone, please remember, when it is your turn to restate your name, give the state you're calling from and what provider or organization you're representing today.

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star then the number one on your telephone keypad. Your

first question comes from Cathy Abben of North Carolina. Your line is now open.

Cathy Abben: Abben, Southeast Radiation Oncology in Charlotte. I wanted to ask again just to verify, on the reporting codes for prostate is 774.27, you have multiple doctors seeing patients over the course of seven to nine weeks. Each time a doctor sees a patient, at least, one of those weeks, we do report individually for that doctor, correct?

Daniel Green: Terri, do you want to take that, is that one of the measures that you all did?

Terri Henning: That is one of the measures that we did and that is what we do. We reported on the one weekly for the physician that is on that weekly service that week that is seeing that patient.

Daniel Green: It would be the correct way to do it because you know, when we calculate the measured results, it's at the individual TIN NPI level.

Cathy Abben: Great. That's what we're doing. Just want to verify. Thanks, Terri.

Terri Henning: Thanks, Kathy.

Operator: Again, to ask a question, please press star then the number one on your telephone keypad. Your next question comes from Marianne Russo, New York. Your line is now open.

Marianne Russo: Hi. I have a question for Dr. Green. We have a practice that's all ready to start practicing. Today is June 1st. And we're looking to report for the sixth month reporting period from July through December. If we start in June, will that negate them from being successful for the six months?

Daniel Green: No, it won't. Are you planning to do the three individual measures?

Marianne Russo: We have three measures that we're looking to start as of July 1. But we're ready now in June so we wanted to get the process starting. So by July 1, we'd be ready to go and report.

Daniel Green: When we analyze the data, we analyze it for 6 months to 12 months, we analyze it for measures, measured groups, registry reporting. So we look across all the different opportunities that an eligible professional would have to report. And then we give them credit for the most favorable ones that they meet.

So even though you start reporting in June, it's highly unlikely, you'll meet the 12-month reporting requirement.

Marianne Russo: Exactly.

Daniel Green: But, again, if you met the six months, you would – that's what we'd pay you on.

Marianne Russo: OK. Great. Thank you so much Dr. Green.

Daniel Green: Thank you. Good luck.

Marianne Russo: Thank you.

Operator: Your next question comes from Cathy Abben of North Carolina. Your line is now open.

Cathy Abben: I had another question. For registry reporting which we did this year – this last year for one of our practices, is it – do you have to report to the registry for a whole year or is that a six month? Thank you.

Daniel Green: You're talking about for 2010?

Cathy Abben: Yes.

Daniel Green: In 2010, I believe there is a six month reporting option. But I'd have to double-check and refer you to the website. I'm sorry I don't have that directly in front of me. But I do believe that most registries also have a 6-month reporting period as well.

Cathy Abben: If you started paper claim but you're planning to go to registry and you already started paper claim this year, and if the option is there for only

six months, will that negate the first six months or how would CMS pick which one to pay you from?

Daniel Green: OK. So what we do, as I mentioned to the previous caller, we – you know we do look across all methods of reporting but what we won't do is we won't you know take, like, four months of claims and add it to eight months of registry or for any part thereof. So we'll look all across registry, we'll look all across claims, but we can't combine two different parts. So ...

Cathy Abben: So, if I started with claims and I stop that and I go to registry for the rest of the year, you'll want one or the other?

Daniel Green: Well, we'll look at both.

Cathy Abben: OK.

Daniel Green: But, right, we won't combine it. Now, what you could do is many registries...

Female: Great. When you're scheduled ...

Daniel Green: I'm sorry?

Cathy Abben: That was somebody else. I don't know what that was.

Daniel Green: Oh, it – what you could do, however, is many registries will allow you to report data kind of in arrears so you could back – I mean, I'm not saying you want to do this necessarily, but many registries have an oppor– , will allow you to report data going back to the beginning of the year. So, whichever registry you're going to use, you might contact them and see if that would be a possibility for them.

Cathy Abben: Well, that's what I'm having to do because we didn't sign our contract with the registry yet. I'm trying to avoid that. I mean, if I can do six months with the registry, it's going to go a lot quicker for me and I don't have to repeat the last six months. But I'll check on the Web site and ...

Daniel Green: Yes. If you have trouble finding it, please call our QualityNet help desk and they'll be able to get a definitive answer for you. Do you need that number again?

Cathy Abben: No, I do not. Thank you so much.

Daniel Green: Thank you. Good luck.

Operator: Your next question comes from Ed Mercardo, Florida. Your line is now open.

Ed Mercardo: Yes. Thank you. This is a question for, Terri. Terri, in 2007 you show that you didn't get a bonus. Do you know why and could you decipher the report that CMS provided in 2007 to correct?

Terri Henning: Unfortunately, we were not able to decipher that. It was a process of – when we went back and looked, and we scoured the report, it appeared in reviewing our system that it's likely that the CPT-2 modifiers were taken off. They were stripped off before they were sent on. It was – it was not something that was apparent through the whole process. Some of the physicians that we reported are all the same, some had no – had no reporting.

We tried to use the fact that it was our first effort, then it was kind of the rollout of the program that we chalked it up to experience. The first reporting, if we would have been asked to do something like this after the first six months, we were pretty discouraged after the amount of time and effort that we had put into it.

Ed Mercardo: Right.

Terri Henning: So, I don't have an answer except that our – our kind of thought was perhaps after they were stripped.

Ed Mercardo: Well, I have a follow-up to that. And you could plead the fifth on this question. Did you have to hire additional staff? And if so, is your

present bonus from the PQRI did define that additional role, additional person?

Terri Henning: I would plead the fifth but I think it's better just to answer it. It did take – we had to hire additional staff, but not specifically for PQRI. Our group was growing, and it was an additional task. There is no doubt that it takes significant hours through the week on top of this in order to do the basis – the claims basis. And we would likely look at changing the way that we do it and no, the bonus does not – from the number of people involved in this process from the physicians through the staff, the bonus does not pay for that.

But as I said, the reason that we did this initially was to be on the ground level. And we went in to this with an expectation that it wasn't about dollars and cents.

Ed Mercardo: Thank you.

Operator: Your next question comes from Peggy McCloskey of Florida. Your line is now open.

Peggy McCloskey: Hi. My question is to clarify the 15 minimum per measure. For example, if a physician has reported on three measures and one, they hit the 80 percent and they had 45 patients, and the other two, they may have only had eight or nine. Does not mean they don't qualify or they qualified based on the one?

Female: (Inaudible).

Peggy McCroskey: Excuse that.

Daniel Green: They would qualify. The 15 and 8 numbers tend to refer more toward the minimum number of patients if you're doing the 80 percent of a measures group. You know what I mean?

Peggy McCloskey: No, I didn't. I thought the 80 percent was per measure.

Daniel Green: Well, it is 80 percent per measure. But the minimum of the – for instance, 15 – now, we're looking for 30 patients in a measures group. Well, if you don't – let's say you did the preventive care measure group, hypothetically, and you didn't have 30 patients that met the denominator of the measure. The second option for a measures group would be that we look at – did you report on 80 percent of the patient for whom you could have reported that particular measures group?

And in that instance, we require a minimum of 15 patients for the year or minimum per year, or 8 patients for half a year.

Peggy McCloskey: OK. So, for individual measure, that's not a 15 minimum? Is that what you're saying?

Daniel Green: No.

Peggy McCloskey: OK. Thank you.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from Stephanie Dutton of Kansas. Your line is now open.

Stephanie Dutton: Thank you. I just had a quick question, and Terri might have alluded to this earlier. We are preparing for PQRI. We have not participated in it yet, but are working on readying for it. And the question continues to surface in regards to whether or not to go with claims submission or go with registry submission.

I was wondering if anybody would address the benefits of registry versus claims or vice versa.

Daniel Green: I mean, I'm happy to take that if you guys like.

Terri Henning: Yes.

Daniel Green: The benefit of – the benefit of registry, first of all, registry participants have had a higher percentage of – both have been eligible by doing the registry. And the biggest advantage is you can collect the data over a

period of time. So as I mentioned, some registries, you could spend all your data in or enter it via their web portal or however they collect their measure information. You could do it in December for the whole year – again, for some registries.

Someone can data mine your electronic health record if you have one in your office and can get the information so there's very little that you end up having to do. And these are some of the advantages of registries. The disadvantages, your registry sometimes will charge you a fee for collecting and aggregating your data and sending it in to us.

So the downside is you know, there may be a fee involved. The upside is you'll have a longer time because we don't allow you know we don't allow you to resubmit claims solely for the purpose of adding these quality data codes. Not to mention, if Mr. Jones comes into your office today and you didn't do the quality action or you hadn't done the quality action, but let's say you ordered whatever particular test was necessary for the measure, you know, and two weeks later the test comes back, you'd have that information so you could meet the, from a performance standpoint, you could meet the measure.

Now, again, we're only paying for reporting. But you know the more accurate the information is, the more it will enable the practice to look at their performance and for quality improvement.

Stephanie Dutton: OK, very good. Thank you.

Daniel Green: Good luck.

Operator: There are no further questions at this time.

Natalie Highsmith: OK. We can now go ahead and end the call now. I'll turn the call over to Dr. Green for closing remarks.

Daniel Green: Thank you, Ms. Highsmith. And I would like to thank our co-presenters today, Terri Henning, thank you so much for your valuable

insight into your perspectives of participating with – in PQRI, and Dr. Neuss – now, will you pronounce it for me?

Natalie Highsmith: Neuss.

Daniel Green: Neuss, I'm sorry. If English weren't my first language, I'd be dangerous. In any case, thank you for the perspective. I know for our audience, we appreciate it to have – an ASCO perspective on PQRI.

We appreciate everyone's attendance today and your interest in the PQRI program. As I mentioned earlier, there is a six month reporting option. So we would encourage you folks that are not participating, please jump on board and try your participation for the second half of 2010. And if you are electronically prescribing, please report that.

The program is pretty easy now with only one G-code and only requiring 25 electronic prescriptions. It should be easy to earn your 2 percent incentive for 2010. And, again, that would be of all your Medicare coverage – part B covered services, so the bonus, you know, could be reasonable for a minimal amount of work.

So, thank you, again, for your attention today and we'll look forward to your participation and questions and participation in the future.

Natalie Highsmith: OK. Sarah, can you tell us the people joined us today?

Operator: At your highest point, you had 150 participants.

Natalie Highsmith: OK. Wonderful. Thank you, everyone.

Terri Henning: Thank you.

Operator: This concludes today's conference call. You may now disconnect.

END