

Centers for Medicare & Medicaid Services
Special Open Door Forum:
2011 Physician Quality Reporting System
and 2011 Electronic Prescribing (eRx) Incentive Program:
Understanding Physician Quality Reporting, Claims-Based Reporting for eRx (to Avoid Future
Payment Adjustments), and
Maintenance of Certification Program Reporting Requirements
Tuesday, January 25, 2011 1:30-3:30 p.m. ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on the 2011 Physician Quality Reporting System (previously known as PQRI) and eRx Incentive programs. This Special Open Door Forum will focus on:

1. Understanding the basics of the 2011 Physician Quality Reporting System, including:
 - 2011 measures and criteria for satisfactory reporting
 - Registry submission
 - EHR submission
 - Group Practice Reporting Option (GPRO) I and II
 - Available resources
2. Understanding claims-based reporting for the 2011 eRx Incentive Program, including:
 - Basics of the eRx Incentive Program
 - A description and overview of the 2012 eRx payment adjustment
 - How to avoid the eRx payment adjustment
 - Hardship exemption guidance
 - A description and overview of the 2013 eRx payment adjustment
 - Available resources
3. Reporting requirements for the Maintenance of Certification Program

Following the presentation, the telephone lines will be opened to allow participants to ask questions of the CMS subject matter experts.

The requirements for the 2011 Physician Quality Reporting System, the 2011 eRx Incentive Program, the 2012 eRx payment adjustment, and the 2013 eRx payment adjustment are described in the 2011 Physician Fee Schedule Final Rule with comment period. The final regulation was published in the Federal Register on November 29, 2010. To view the entire 2011 PFS Final Rule with comment period, go to the CMS PQRI website at http://www.ofr.gov/OFRUpload/OFRData/2010-27969_PL.pdf.

Presentation materials will be posted to the CMS Sponsored Calls page of the CMS Physician Quality Reporting website at <http://www.cms.gov/pqri/>.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial 1-800-837-1935 Conference ID 34438298

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and 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 beginning on or around February 25, 2011.

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.

Transcript & Audio File –

http://media.cms.hhs.gov/audio/01-2511_SODF_Physician_Quality_Reporting_System.mp3

Centers for Medicare & Medicaid Services

Moderator: Barbara Cebuhar
January 25, 2011
1:30 p.m. ET

Operator: Good afternoon, my name is Shannon and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Physician Quality Reporting System Special Open Door Forum. 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, simply press star then the number one on your telephone keypad. If you would like to withdraw your question press the pound key. Thank you. Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Thank you Shannon, good afternoon and welcome to the special open door forum for the Physician Quality Reporting System and the electronic prescribing initiative program. My name is Barbara Cebuhar; I work in the Office of External Affairs here at CMS. We are pleased to have several members of our Office of Clinical Standards and Quality on the line today to help us understand the many issues associated with those two programs.

Before I introduce them though I would like to make sure that those of you at your computers have access to the reference slides that will be discussed on today's call, you can get them at the sponsored call pages in the download section at http://www.cms.gov/pqri/04_cmssponsoredcalls.asp#topofpage. I'll repeat that for you just in case you need to get access to the slide, that's http://www.cms.gov/pqri/04_cmssponsoredcalls.asp#topofpage.

Now I would like to introduce our subject matter experts from the Office of Clinical Standards and Quality. First we will hear from Jacquelyn Kosh-Suber who will provide some announcements that I know stand to affect many of you. Secondly we will hear from Dan Green who will talk about the basics of the 2011 Physician Quality Reporting System as well as provide some important background for the 2011 Electronic Prescribing Initiative program including future e-Prescribing payment adjustments. Finally we will hear about reporting requirements for the Maintenance of Certification Program from Molly MacHarris. Then we will take your questions at the end of the presentation.

Just a reminder if you need assistance with the Physician Quality Reporting Program you can call the QualityNet helpdesk at 866-288-8912 that's available from 7:00 to 7:00 – 7:00 am to 7:00 pm Central Time Monday to Friday or you can send e-mail to qnetsupport@sdps.org or you are also available – you are also able to call the TTY number which is 877-715-6222.

I just wanted folks to also know that there will be an encore presentation of this call available until midnight on January 28th that's Friday the 28th by calling 800-642-1687 and using the reference number 34438298. A recording and a transcript will be available on the Special Open Door Forum Web site

starting February 25th that will be accessible for downloading. Jacquie do you want to go ahead with your announcements?

Jacquelyn Kosh-Suber: Yes, thank you Barb, good afternoon everyone. I just want to start off with a few announcements that are important to the PQRS program, one of the very first announcement that I would like to discuss is beginning January 1st of this year all the professionals who are requesting feedback reports be it the alternative request process will be as what year they want the feedback report and what type of feedback report they want i.e. the physician quality report system, e-prescribing this in the program, the quality and resource use report or all of the above reports.

All the professionals who are using a Registry to submit their 2010 Physician Quality Reporting System and/ or e-Prescribing Incentive Program results need to make sure that they are providing the Registry with their individual NPI and not the group NPI.

We understand we've had several issues with users in IACS accounts thus people have had problem with access to the 2009 PQRI and e-Prescribing feedback report we apologize for this inconvenience. Some of the issues centered around the IACS account approval process being transferred to the Quality Net helpdesk. In the transfers there were issues with new roles in the coordinate helpdesk that caused approval delays, these delays have been corrected and addressed and the accounts are now being reviewed and approved.

Please note there are many in the queue so that might take a little while to process the pending request. In the meantime another option that we have for those who are interested in obtaining for individual NPI level feedback report is to call the Medicare carrier as we simply request the individual NPI feedback report for 2009 PQRI or your 2009 e-Prescribing-Incentive Program

We are currently having a call for – our Call for Measures for our accountholders for 2012 is over. The measures that were chosen, the list of individual measures and measures group are now available on the PQRI site

on the measure page in the download section. Registration for the 2012 measures Town Hall that is on February 9th will close on January the 28th at 5:00 p.m.

I would like to remind all eligible professionals to use their 2011 measures specifications which since the beginning of the year is on the PQRI page on the measures code section and download all the specifications are there along with the implementation guideline for 2011 and a final announcement that I have is on the physicians compare. The Physicians Compare Web site was launched on December 30th 2010 and includes information about physicians and other professionals with satisfactorily reported quality measures for the 2009 Physician Quality Reporting System.

It doesn't yet contain physician and eligible professional performance information. You can access this Web site at <http://www.medicare.gov/find-a-doctor/provider-search.aspx>. You must be enrolled in the provider enrollment chain and ownership system otherwise known as PECOS as of October 2010 to be included in the Physician Compare Web site.

If you submitted information to yourMAC the profile update may appear in the February 2011 refresh of the Physician Compare and the note to the provider section there are several detailed instruction if you are enrolled in PECOS but missing from the Web site. If you feel that you satisfactorily reported quality measures for the 2009 Physician Quality Reporting System you are also enrolled in PECOS and are not listed on the Web site please contact the QualityNet helpdesk for assistance.

The helpdesk can be reached at 1-866-288-8912 or if you would like to e-mail them you can e-mail them at qnetsupport@sdps.org. For any additional information you need on PECOS please visit <https://www.cms.gov/medicareprovidersupenrol> and you may find helpful information and the reference download.

Now Molly MacHarris would like to give you some information on a new FAQ that we have on performance rate for Registry. Thank you, Molly.

Molly MacHarris: Thanks Jacquie, this FAQ is to address the new rule for the 2011 Physician Quality Reporting systems that information received through Registry based reporting, if those measures have a zero percent performance rate it will not be counted. With this FAQ you will get a little bit more information on how we will be implementing that.

The zero performance for Registry based reporting that is mentioned in the 2011 final physician fee schedule rules as it is intended to only eligible professional if you never performed the quality actions for any of the eligible patients for a measure or measures within the measures group the eligible professional was intending to report. An eligible professional reporting via Registry for a measures group need to report all the measures in the group that are applicable to the population that is reported with a reporting rate of greater than or equal to 80 percent or 30 unique patients and they must include a performance rate of greater than zero.

For each applicable measures during the specified reporting period to be considered and stand as eligible. In case of where a measure within the measures group is not applicable to the patient, the patient will not be counted in the performance nominated for that measure. For those patients shouldn't be affected and an example of that would be the prevented care measure group, measure 39 Screening or Therapy for Osteoporosis for Women will not be applicable to male patients according the male sample criteria. However it is unlikely that a measure within a measure group would not be applicable to any of the patients that are reported and maybe subject to investigation in specific case.

An eligible professional reporting via Registry for individual measures need to report at least three measures with a reporting rate of greater than or equal to 80 percent and a performance rate greater than zero during a specified reporting period to be considered and stand as eligible. Measures reported by an eligible professional via our Registry with a zero percent performance rate will not be counted as a reported measure when determining the incentive eligibility.

Therefore the provider which may not receive an incentive payment for the 2011 Physician Quality Reporting System if they don't follow this three measures reported satisfactory with a greater than zero percent performance rate. And well I'm not (inaudible) with measures with a lower performance rate indicates better performance in those measures would count as reported if less than 100 percent performance rate as reported by the Registry.

And one more clarification for the 2011 measures group for Registry based reporting, in the past you were able to receive non Medicare beneficiary, for 2011 the 30 patients must all be Medicare. They can be unique however they don't need to be consecutive. That is my announcement, now I'll turn it back to Jacquie Kosh-Suber.

Jacquelyn Kosh-Suber: I wanted to give some information on upcoming calls and meeting that we have on January 27th, we will have a National Provider Call from 1:30 to 3:00. This is the call that was scheduled for January 18th and had to be rescheduled. During this call we will provide information on EHR submission, the e-Prescribing payment adjustments and CMS incentive program difference. February 9th is the Town Hall and that meeting is from 10 o'clock until 4:00 and I give that information early on the deadline January 28th to register and our next National Provider Call will be February 15th from 2:30 to 4 o'clock.

Now we will start with our PowerPoint presentation that we have. I hope everyone had an opportunity to download. Dr. Green will provide the first presentation on the basics on the 2011 Physician Quality Reporting System

Dr. Daniel Green: Thanks Jacquie and welcome everybody. Thanks for dialing in today, I know if you are in the Baltimore area, you are dripping out one of our warm days I think the temperature might even reach close to 40 today, it's nearly beach weather compared to what we are used to and hope you are all warm wherever you are calling in from.

Rather than listening to me for an extended period of time, we've been lucky enough to have Michelle Allender-Smith all the way to us from the third floor of our building. Michelle is a nurse who is the lead staff person so she is going to actually do the first part of the presentation about the Physician

Quality Reporting System overview or basics that's what we are going to do and then I'll pick up with the e-Prescribing.

So without further ado, Michelle.

Michelle Allender-Smith: Thank you Dr. Green. If you all have the slides, I'll be starting on page five which is pretty basic about what is Physician Quality Reporting and before I get started those of you that have been participating in the programs for a while knew that the program was referred to as PQRI and now going forward the program is referred to as Physician Quality Reporting System or you will hear folks say just Physician Quality Reporting.

So with that Physician Quality Reporting is a voluntary program. As many of you know we begin in 2007 and was originally called PQRI. Eligible professionals and/or group practices will satisfactorily report data on quality measures for covered Physician Fee Schedule service furnished to the Medicare Part B beneficiaries will qualify to earn an incentive payment.

The incentive payment is a percentage of the eligible professional or groups estimated total Medicare Part B Physician Fee Schedule allowed charges and those percentages are determined yearly. Overtime the program has expanded the number of measures and reporting options to facilitate quality reporting by a broad array of eligible professionals. If you turn to slide 6, you will see a depiction that displays from 2007 to present since the program started and the respective legislation that passed that allowed the program to expand at measures and add the various reporting option. So you will see that we've grown from 74 measures to a 170 measures and increase the number of measures group and the reporting options.

On page seven, how do you determine the eligibility well first of all there is a list of eligible professionals who can participate in the program and/or e-Prescribing Incentive Program that are posted on our Web site and currently the Web site is still www.cms.gov/pqri. Sometime in April the link will change but for now the link is still the same www.cms.gov/pqri and for e-Prescribing it's www.cms.gov/e-Prescribingincentives. People are NOT eligible if they are reimbursed by Medicare under methods or fee schedules

other than the Physician Fee Schedule. Federally Qualified Health Centers are not eligible to report Physician Quality Reporting data because they are not reimbursed under the Physician Fee Schedule.

Eligible professionals include physicians, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, and many other health care professionals. When we look at the make-up of the measures specification, you will often hear about what's included the denominator of the measure but there is also a numerator in that measure.

The numerator is the clinical action required for that performance and then within the denominator that describes eligible cases for which a clinical action was performed. The eligible patient population is defined by the numerator specification. So when you take a look at a measure spec you will see what's included in that clinical action which is the numerator and then all those codes and eligible cases would be in the denominator.

On page nine 2011 Physician Quality Reporting, the reporting of those quality measures there are large selection of measures to choose from. We have individual measures and group measures, individuals can participate individually or in large groups and/or small groups. Those large groups are referred to as our group practice reporting option one and now we will have a group practice reporting option two which is considered the small group. Additional incentive of 0.5 percent is added for this year for maintenance of certification program which Molly MacHarris will talk about a little bit later this afternoon.

We have various methods of reporting as I mentioned through qualified EHR those are electronic health record, qualified Registry and claims processing. The group practice reporting option one measures database submission methods and then we will also have group practice reporting option two. Incentives are independent of participation and other CMS programs so we get a lot of calls, e-mails, questions about the overlap of programs but the Physician Quality Reporting System program is separate, the e-Prescribing program is separate, our HITECH program is separate, the audit

demonstration program are separate. So they are all – for them, CMS have their separate program.

On page 10, there is a decision tree that I actually believe Dr. Green put together when folks are looking at but I want to participate and what the incentives associated with it or what do I need to do if I'm reporting six months versus 12 months. Am I going to use the claims methods, am I going to subscribe to a Registry and have that aspect for reporting, do I have an electronic health record in my office system that's qualified, am I going to report through that or am I going to report if the GPRO 1 which is a group practice that has 200 or more physicians and the group practice two which is the small groups are it's anywhere from two to 199 in the GPRO 2.

So when you have an opportunity you can go through this diagram and it will help you make some of those decisions. It's also a continuation of that decision tree on page 11 that gives a more clear depiction about the 12 month reporting options which apparently is January 1st 2011 through December 31st of 2011 for the 12 month reporting option and six month reporting option is July 1st 2011 through December 31st 2011.

Slide 12, what is actually satisfactory reporting well you don't have to register. There is no registration for individual participants. However if you are in a large group practice or the small group practice and you wish to report as a group you must self-nominate and then be selected by CMS to participate as a GPRO 1 or GPRO 2. Those reporting through Registry or EHR methods must use a qualified Registry or an electronic health record software.

Claims reporting rate for 2011 is at 50 percent rate, it was 80 percent so it's 50 percent in 2011. If you are using a Registry or EHR reporting it's 80 percent reporting rate. For GPRO reporting there is a complete patients sample and there will be four diseases modules and all of the preventive care measures as well.

There are 194 measures including five new measures for claims and Registry reporting. There are 11 new Registry only measures and there are four new measures for electronic health record based reporting only. If you are

interested in more information on group practice reporting, you can go to the CMS Web site and you will find additional information about GPRO 1 and 2 and more information about what that's self-nomination process is all about.

On slide 14, there are 20 electronic health record measures. There are 14 measures that are listed the 14 measure group that is and I won't read through those but I'll give you a minute to preview that page and you can take a look at those 14 measure group.

On slide 15, we give you a depiction of the claims reporting for 2011 so if you are selecting the claims method for reporting in 2011 for individual's measures again the reporting period is the full year January 1st through December 31st 2011. The physician will have to report at least or the eligible professional would have to report three Physician Quality Reporting System measures or 1-2 measures if fewer than three applies.

If you are using the 6 month reporting option which begins in July, July 1st 2011 through December 31st 2011 then the eligible professional would report each measures for at least 50 percent of the applicable Medicare Part B Physicians Fee Schedule patients seen during the reporting period so that's the change. Previously it was 80 percent now it's 50 percent for eligible professionals using the claims method for reporting.

Eligible professional to report on fewer than three measures may be subject to the Measure Applicability Validation process which you may refer to or hear us refer to MAV. Slide 16, we talk about the reporting option for Registry and EHR, we have the same reporting period for Registry there is a 12 month reporting option or a six month reporting options. The difference here is that the reporting rate for each measure is 80 percent as you know with claims it's 50 percent. So you will have to report at least three Physician Quality Reporting System measures if you are using the Registry and each measure at least 80 percent of the applicable Medicare Part B Physicians Fee Schedule patients seen during that reporting period.

With EHR, there is only a 12 month reporting period, there is no six month. Again EHR is a full 12 months again you have to report at least three

Physician Quality Reporting EHR measures and those measures are again at least 80 percent of the applicable Medicare Part B Physicians Fee Schedule patients seen during the reporting period. Measures with a zero percent performance rate will not be counted. In the past we did count those but going forward we will not so if the measures that is zero percent performance you will not get credit for that.

Slide 17, reporting option using claims or Registry for measures group again this is a 12 months reporting period. You will need to report at least one Physician Quality Reporting System measures group and report each measures group for 30 Medicare Physician Fee Schedule patients seen during that period. This is also a change from prior year it had to be 30 consecutive patients and now it's just 30 patients. For Registry based reporting measures group with a zero percent rate again we will not count those records.

Eligible professionals reporting measures group using the Registry based reporting mechanism will no longer be able to report on non-Medicare Physicians Fee Schedule patients and again this is new I think prior had to be just two patients but now they all have to be Medicare patients.

Slide 18, it measures group again but if you are using the claims method for reporting measures group. It's again a full 12 months and the eligible professional would need to report at least one Physician Quality Reporting System measures group and because you are using claims, it's 50 percent rate versus a 80 percent rate of the applicable Medicare Part B Physicians Fee Schedule patients seen during this period. And also you can report at least report each measure group for at least 15 Medicare Part B Physicians Fee Schedule patients seen during that time.

For measures group again claims July 1st through December 31st the six month option for measures group again reporting at least one Physician Quality Reporting System measure is that the 50 percent of applicable Medicare Part B Physicians Fee Schedule patients seen and also report each measures group for at least eight Medicare Part B Physicians Fee Schedule patients seen during that reporting period.

If you are going to report the measures group and I'm now on slide 20 through a Registry using a 12 months reporting option January 1st through December 31st 2011, same idea, report at least one Physician Quality Reporting System measures group because you are using a Registry and not claims is at 80 percent and then report each measures group for at least 15 Medicare Part B of those patients.

If you are using a Registry and you are going to report using the six month option which begins July 1st, same thing report one at least Physician Quality Reporting measures group and it's also at the 80 percent rate and report each measures group using at least Medicare Part B. So if you are doing Registry for 12 months is at 80 percent and it's on 15 Medicare Part B if you are doing Registry for six months you report at least one Physician Quality Reporting measure at 80 percent on eight Medicare Part B patients. And again just a reminder measures group with a zero percent performance rate will not be counted.

On slide 22, we often get a lot of questions about what is a Registry and the Registry actually captures and stores all the clinical related data submitted by the eligible professional or the group practice. The Registry in turn submits that information to the Physician Quality Reporting System on individual measures or measures group or the e-prescribing measures to CMS on behalf of the eligible professional or the group practice. Registries provide CMS with calculated reporting and performance rate at the end of the reporting period, 12 months and six months option. Data must be submitted to CMS via a defined xml specification.

CMS qualifies the Registries annually and we currently have a list of the qualified Registry for 2010 for Physician Quality Reporting on our Web site and if you take a look at page 22 the link is at the bottom. This is a direct link that will take you to the qualified Registry however if you just go to www.cms.gov and you type in qualified Registry they will also take you to that information.

On slide 23, CMS also qualifies EHR vendors annually as well and we have a list of the qualified EHR vendors for the 2011 Physician Quality Reporting

and e-Prescribing Incentive Program including the specific products and the versions that are qualified and those are available on the CMS Web site. On slide 23 it gives you the full link that will take you directly to that information but just as I said for Registries if you put in www.cms.gov go to that page and then just type in EHR vendors it will still take you to that information. Using a qualified electronic health record, eligible professionals can submit raw clinical data to CMS and measures are calculated by CMS.

For group practice reporting options, to participate in the group practice the group practice must self-nominate and that's sending a letter to CMS with information that is posted on the Group Practice Reporting Options section of the Physician Quality Reporting Web site. As I mentioned earlier if you go to the Web site and you put GPRO or GPRO 1 it will take you to that information and give you instructions on exactly what you need to do if you want to look at the opportunity to participate in GPRO 1 and that is the group practice that is 200 or more NPI participating under its tent is what we consider as GPRO 1. You have to meet certain technical and/or other requirements and you have to be selected to participate.

There is also a pre-populated database that is a collection tool that is assigned, is an assigned set of Medicare beneficiaries that would need to be completed. There are 26 total measures in that module. There are four disease modules, four individuals preventive care measures. That tool, also the (inaudible) for that tool is no later than the first quarter of 2012. So 2011 data is actually been submitted in 2012.

They also hold a series of informational sections for the groups that have decided to participate in GPRO 1 and that has been selected. So you get a lot more detail if you are selected to participate in Group Practice Reporting Options so they will go over more thoroughly what those options are specifically how you enter the data into the tool, what's the exchange on that tool and a lot more details. So if you are selected you will get a lot more information about GPRO 1.

For GPRO 2 for 2011 that's the group practice where you have less than 200 so group practices with 2 to 199 eligible professionals or that would be the

numbers of NPIs participating under the for 2011 will be considered a group practice reporting option 2. CMS will select an approximately 500 groups to participate in its option that meets the eligibility requirements reporting via claims unless only applicable with measures group that are Registry based only. There isn't a data collection tool for GPRO 2, for GPRO 1 there is a data collection tool. So 2011 Physician Quality Reporting System individual measures specification for claims and Registries will be used as well as the 2011 Physician Quality Reporting System Measures Group Specification Manual.

So how do you participate in GPRO for 2011, to be eligible for Group Practice reporting potential participants must meet the group practice definitions that's first and you have to have billed Medicare Part B on or after January 1st 2010 and prior to October 29th of 2010?

You also must self-nominate so for GPRO 1 as I mentioned practices must currently be practicing in 2010 GPRO and notify CMS via e-mail if planning to continue their participation. Additionally the GPRO will need to provide the group practice TIN and agree to attend and participate in mandatory training sessions and kickoff meeting. And those are to benefit and facilitate those group practices participating in GPRO.

If you look at slide 28, there are some deadlines that are already in place a lot of this information is of course is posted since 2010 but for GPRO the self-nomination letter has to be received by January 31st 2011. So you still have some time for GPRO 1 and for GPRO 2 you must self-nominate as well and this is new so it started January 1st through the 31st of 2011. All claims must be received by the end of February 2012. Registry, EHR and GPRO 1 must submit all data by the end of March 2012. Maintenance of Certification information must be received by the end of March 2012 as well.

Qualified Registry, EHR software and maintenance of certification entities will be listed on the CMS Web site. If you need additional information on how to get started you can also go to our CMS Web site www.cms.gov/pqri there will be a list of the 2011 measures, the measures specifications for individual measures reporting. There will be measures group specifications,

EHR specifications, GPRO 1 specifications and the 2011 implementation guide as well as what's new for 2011 for Physician Quality Reporting.

You can also take a look at the frequently asked questions. There is also supplemental education material, National Providers Calls that we hold pretty much monthly, Special Open Door Forums such as what we are doing today and we remind you to use the measures specifications for the current program year. Some folks who have participated year after year that maybe reporting the same measures, the measures specification can change from year-to-year.

So we are in 2011 so make sure you are looking at 2011 measures specification. And as always we have our QualityNet Helpdesk and they can help you with portal password issues, feedback report availability and access, Physician Quality Reporting IACS registration as well as if you are having login issues with IACS and if you have questions about the program whether it be Physician Quality Reporting or e-Prescribing, questions around the measures specification folks on the QualityNet Helpdesk can help you out.

So their number is 866-288-8912 and they also have an e-mail address which is qnetsupport@sdps.org and the TTY number is 877-715-6222. Thank you for your time and I'll turn it over this portion of the presentation to Dr. Dan Green.

Dr. Daniel Green: Thanks Michelle, great overview of the PQRS program, thank you for leading us through that. We are now going to be looking at slide number 33; we are going to talk about the Electronic Prescribing Program. We've got a lot of questions about the Electronic Prescribing Program, there is some confusion between the e-Prescribing-Incentive Program as well as Meaningful Use /HITECH program and what's required with each program, are they mutually exclusive et cetera.

For most folks, it's important to know that they need to do electronically prescribe at least 10 prescriptions using a qualified system in the first six months of 2011. And this is necessary to avoid a prospective payment adjustment which would take place in 2012. So we will go into that a little bit more detailed in this presentation but when we mention the word payment

adjustments people obviously get concerned about that and are looking to do what they need to do to avoid that from taking place.

So looking again on slide 33, we can see that electronic prescribing is the transmission of prescriptions or prescription-related information through electronic media. It typically takes place between a prescriber, a dispenser aka pharmacy, or pharmacy benefit manager or health plan so this would be the drug benefit portion of your healthcare coverage. It can take place directly or through an intermediary so some places like Kaiser may shoot the prescription directly to their pharmacy from their provider's office whereas if you are in a private practice setting you may go through something like Surescripts, the Surescripts network to send that prescription.

On slide 34, you can see that the e-Prescribing-Incentive Program was authorized by MIPPA; the Medicare Improvements for Patients and Providers Act of 2008 and the idea of course is to promote the adoption and use of electronic prescribing. There are a combination of incentive and payment adjustment through individual eligible professionals and group practices again to encourage the electronic prescribing. We have a Web site dedicated to the e-Prescribing-Incentive Program and we would encourage you to visit it early in office that address is www.cms.gov/e-Prescribingincentive so there is a lot of useful information we would encourage you to check out the Web site.

On slide 35, the e-Prescribing-Incentive is similar to the Physician Quality Reporting that is based on Medicare Part B Physicians Fee Schedule covered professional services better furnished by the eligible professionals during the reporting period. To be incentive eligible, an eligible professional must meet the criteria for being a successful electronic prescriber. The criteria is established for each program year through our rulemaking process so very profound statement to be successful you have to be successful.

But if you do look on slide 36, you can see an outline of our claims based process how folks can get this information into us so basically they see a patient in the office, they have an encounter form billing form which would go to their coding and billing folks. They would attend if they use the qualified

electronic prescribing systems to create an electronic prescription they would append a G8553 code and the billing folks would upload this to the Carrier or MAC.

The Carrier MAC is going to ultimately send back an M365 code basically saying that it's a non-payable charge but that means that we got your G code. Once the Carrier MAC has this, they pass it to our National Claims History Files which shows subsequently to our analysis contractor and we use that to populate the confidential feedback report and to also calculate whether the eligible professional is indeed do an incentive payment just as the case we also calculate that and we transmit that to the Carrier or MAC who in turn sends it back to the eligible professionals.

So to determine whether or not you are eligible to participate in the program as you can see on slide 37, there is a list of professionals who are eligible and able to receive an incentive for participating in the e-Prescribing-Prescribing Incentive Program and again that's on our Web site the address I gave you before as www.cms.gov/e-Prescribingincentive.

On slide 38, step two you want to review the slide says 2010 e-Prescribing Measure Specifications which is great but that would more for historical purposes and now you probably want to review the 2011 e-Prescribing-Prescribing measure specification which by the way is pretty much the same but review it anyway. It is available – it's downloadable document the e- Prescribing measure sections of the CMS electronic prescribing Web site. So you want to determine if this measure applies to your practices and then you want to determine if your practice has the resources needed to participate so basically do you have a (inaudible) qualified electronic prescribing system or programs that you are using routinely.

When we define a qualified electronic prescribing program or system as one that can generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers that's available and that's important because you can imagine if you are giving Mrs. Smith a prescription and Dr. Jones down street is giving a prescription you would want to know all the prescription that Mrs. Smith is

taking. And she may forget tell you certain prescriptions or what have but it could impact and affect what medication you are actually chose to prescribe and certainly and what (inaudible) use et cetera.

So with a qualified system if the pharmacy is able to generate and transmit this information to you or the pharmacy benefit manager in other words saying hey we paid for a data block for medication last month for this patient and we paid for a diuretic basically that can help you populate the medication list if the patient is unable to give you a complete medication list.

Additionally a qualified system should be able to select medication print prescription, electronically transmit prescriptions that conduct all safety alerts which would include prior dosage, allergies or drug sensitive, drug interactions and things like that. The system should also be able to provide information related to lower cost therapeutically appropriate alternatives if there are any.

Tiered formulary information will meet the requirement for 2011. It should also provide information on formulary or tiered formulary medication patient eligibility and authorization requirements that would be received electronically from the patient's drug plan so if you are using a particularly expensive medication that requires prior authorization your system should be able to receive that from the pharmacy benefit manager when you are enquiring about prescribing the drug.

If the pharmacy benefit manger's system is capable of transmitting it so we realize that many PBMs can't do that at this point, that's fine but your system has to have the capability to receive it and the reason behind that is we want to encourage people not to buy systems that will be obsolete in the next year or two.

So looking on slide 40, you can look at step 3 to see whether you expect your Medicare Part B Physicians Fee-for-Services charges for the codes that are in the denominator of the measured, you can see those codes listed on the slide so those codes make up at least 10 percent of your total Medicare Part Physicians Fee for Service charges for 2011.

So in other words you could see many of these are regular ENM codes that your average doc would see in the course of their practice. So the charges for this code compared to your total charges comprised at least 10 percent so if you are gastroenterology and you are doing colonoscopy and let's say 85 percent of your Medicare charges for your Medicare patients are actually colonoscopy procedure but 15 percent are in the 99201 through 205 or 211 through 215 you would be OK. You would qualify for this measure.

If on the other hand 91 percent were colonoscopies and only nine percent were comprised of codes in the denominator then no the measure would not apply to you or wouldn't be able to earn an incentive. So what you've decided to do participate in the 2011 program follow the steps for reporting this measure.

You can chose step 1 on slide 42, you must bill one of the CPT codes or HCPCS G-codes that we've talked about in slide number 40 for the patients that you are seeing and then there is only one G-code now and that's and you want to put that on the claim form for the Medicare patient that's basically G8553 which says at least one prescription was created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

So the patient has to have an office visit basically if they call you on the weekend because they have an upper respiratory and you happen to prescribe medication electronically at that time that would not count as one of the required prescription the patient will have to be in the office and you have to seeing them for one of this level of service and then you have to send one prescription.

And it could to path that during your visit you prescribe atenolol for Mrs. Jones but Mrs. Jones is also having a tremendous amount of back pain and so you decide to give her an narcotic and let's say your system doesn't have the capability to prescribe the narcotic electronically that's fine if you send the atenolol electronically and write up a prescription for the narcotics you would

still be able to report the G8533 because it says at least one prescription was send electronically.

Looking on slide 44 we define a successful electronic prescriber who can receive an incentive payment as a person who must generate and report one or more electronic prescription associated with the patient visits, has to be a minimum of 25 unique visits during the year for individuals and the number for group practices is varied on whether you are a GPRO 1 or GPRO 2. GPRO 1 are 2500, GPRO 2 depend on the size of the group. So each visit must be accompanied by the e-Prescribing G-code which basically says that you've created at least one prescription and send it electronically.

Electronically generated refilled if the patient is in the office for visit would count actually taxes however don't qualify as e-prescribing so Mrs. Jones comes in and need to refill on her atenolol you send it electronically as opposed to just giving a voice over on the phone to the pharmacy that is OK but if she is actually in your office and you are generating and sending electronically that would count.

New prescription not associated with a code in the denominator of the measures are not accepted as eligible patients visit and count towards the minimum number of electronic prescription that are required. Additionally 10 percent of an eligible professionals or group practice Part B Physicians Fee Schedule charges must be comprised of codes in the denominator. We kind of talked about that earlier when I gave you the gastroenterology example.

What do the codes mean? Each measure has detailed specifications consisting of the reporting numerator and reporting denominator. The numerator is that G8533 that I was talking about and basically it's saying an electronically prescribing event occurred. The denominator dictates who are the eligible codes for whom the measure should be reported so basically it talks about which patients would be included in the measure.

In 2011, we are now on slide 47, e-prescribing program details one percent of the folks that successfully electronically prescribe basically 25 times and again it could be – you could have Mrs. Jones that comes in February 1st and

then comes in February 14th and if you generate electronically prescription for her at each visit that would count as two count even though it's the same patient.

But if you electronically prescribe five prescriptions for her at the same visit that certainly count as one of the required 25. In any case folks can report the measure via claims, through a qualified Registry or a qualified EHR and the list of qualified EHRs and Registries are on our Physician Reporting System Web site that Michelle talked about earlier. In any case if you report 25 times and have at least 10 percent of your charges comprised of codes in the denominator of the measure you would be eligible for one percent incentive payments 2011.

The reporting period is January 1st through December 31st, you don't need to register because just state e-Prescribing incentive programs unless you are participating as a group practice through the group practice method.

On slide 48, successful reporting of the 2011 e-Prescribing Incentive Program again there is that single G-code that we've talked about 8533. So the G-code has to be put on the claim with the denominator billing for the same beneficiary for the same date of service and by the same knowledgeable professional basically individual NPIs who perform covered services as the payment code.

The electronic prescribing G-code must be submitted with the line item charge of zero dollars at the time it's associated for the covered service performance. Some programs don't allow us \$0 so you may have to do at a nominal charge such as \$0.01. The entire claims with a zero charge with a zero charge will be rejected so if you are submitting a claim only with this G-code it would be rejected.

It has to come in with the E&N service or whatever other services that you may have provided that appears with denominator of the measure. The electronic prescribing line items will be denied for payments but are passed through the claims processing to the National Claims History Database as we saw in that systematic diagram earlier. Again you will get that code N365 that

basically says this procedure code is not payable and it's reporting information purposes only. So again that's kind of your check that we did actually receive that code. It doesn't tell you that the code is accurate it just tells you that we did receive one of these CPT 2 or G-codes.

The solo practitioners should follow their normal billing practices of placing their individual NPI in the billing provider field which basically #33a on the CMS 1500 form or the electronically equivalent. This is really important claims cannot be resubmitted for the sole purpose of adding or correcting an e-prescribing G-code so if the claim is rejected because you put down the wrong CPT code that's one thing. You have to correct that and you could send it again with your e-Prescribing code but if you want to resubmit the claims solely for adding the G-codes that's not acceptable.

Slide 53 gives a pictorial of what a claim form looks like and I think that fairly self-explanatory. And then on 54 you can see that the e-Prescribing G-codes submitted to Carrier MAC either through electronic submission is in the ASC X12N healthcare claim transaction version 4010A1 or the paper based submission which we talked about which was the 1500.

Slide 55 talks more about the billing, more billing details in terms of submitting the e-Prescribing G-codes and I think that's pretty clear people can read that and also can look back at the electronic – the picture we have of the claim form that was on the previous slide.

Now looking at slide number 58 sorry just turning pages here, group self-nominating for the 2011 GPRO 1 or 2 must indicate whether they intend to report the e-Prescribing measure as a group practice or individually, so folks that are sending in their GPRO 1 or 2 nominations again should include that they want to report e-Prescribing as a group or again as individual that's very important. Information on the electronic prescribing measures for GPRO is located on the group practice reporting option section of the CMS electronic prescribing Web site.

This is a question that we often are asked and on slide 59 the electronic prescribing payment adjustments, the legislation calls out for CMS to make

payment adjustments for eligible professionals who are not successful electronic prescribers and this applies whether or not the eligible professionals is planning to participate in the e-Prescribing Incentive Program.

So the requirement supplied is determined if the payment adjustment will or will not be levied not to determine the incentive eligibility. So in 2012 if someone is not a success – if someone doesn't report the e-Prescribing measure the G8533 at least on at least ten claims in the first six months of 2011 they will be subject to the payment adjustment which basically means in 2012 starting January 1st 2012 they will receive 99 percent of an eligible professionals or group practice Part B covered services. In 2013 this is reduced to 98.5 percent so basically it's 1.5 percent payment adjustment 2013.

On slide 60, you could see that the reporting period as I mentioned is January 1 to June 30th so you have until July 31st to get that claim in for services for claims up until June 30th of 2011 and again you can only report through claims, you can't report through Registries or EHRs for the six month and you have to get in at least 10 electronic prescribing events very important.

Earning an electronic prescribing incentive that is doing 25 e-prescribing events between January and December for 2011 will not exempt you from the payment adjustment. I know it's a little bit confusing but it's important to recognize. You could conceivably get a payment incentive of one percent but also be subject to the payment adjustments.

In other words if you don't do your 10 prescriptions in the first six month of 2011 let's say you do five in the first six months and the other 20 in the second six month you would have done 25 for the year so you would be eligible for the incentive payment again assuming 10 percent of your charges are comprised of codes the denominator but you would also get the payment adjustment because you only did five of the required 10 in the first six months.

My suggestion is start early, start now get sure at least 10 in and then if you want to do all 25 in the first six month great then you will have to report anything else to us although we always encourage people to report just a few

extra just to be on the safe side. But get them all in early my wife texted me earlier today she has already done four for this year so she is like half way home almost to avoid the payment adjustments.

In any case on slide 61, how can you avoid the payment adjustment 2012? Well if you are not a physician's meaning MD, DO or podiatrist, nurse practitioner or physician assistant as of June 30, 2011 and we look at this taxonomy code provided in our NPPES system.

Another way you can avoid the payment adjustment is to be eligible professional reports the G-codes indicating that he/she doesn't have a prescribing privileges at least once on a claim prior to June 30th of 2011 so if you don't have a prescribing privileges you can report G8644 that G-codes is on our Web site on a claim prior to June 30th saying I don't have a DA I don't have a prescribing privileges. It doesn't apply to me. Also if you don't have at least 100 cases that contain an encounter code in the denominator of the measure you are also exempt.

So if you only see 50 Medicare patients in the first six month that have 99206 or 205 rather or whatever and that's the only code you billed wouldn't apply to you. You have to have at least 100 denominator eligible patients.

You also have to meet the 10 percent denominator threshold; if only five percent of your charges are comprised of codes in the denominator again you wouldn't be subject to the payment adjustments. Also you can avoid the payment adjustment as we talked about becoming a successful electronic prescriber by reporting at least 10 unique e-Prescribing events for patients in the denominator of the measure.

For group practice participating in the GPRO 1 or 2 during 2011 basically it's going to depend on the size of the group in terms of how many prescriptions you need to get in but you will need to get in whatever the number is depending on your group size. You will need to get all those prescriptions and claim codes in between January 1st and June 30th and on slide 63 you can see a table based on the group size and the number of required e-prescribing events to avoid the payment adjustments.

On slide 64 there is a hardship exemption, where CMS on a case-by-case basis may exempt some individual eligible professional from the application of the payment adjustment if compliance with the requirement for being a successful e-prescriber would result in a significant hardship. The hardship exemption is subject to an annual renewal and for 2012 e-Prescribing payment adjustment we've outlined two circumstances the eligible professional practices in the rural area with limited hi speed Internet access or the eligible professional practice is very limited available pharmacies that can receive electronic prescriptions.

We've created two G-codes 8642 and G8643 to request a hardship exemption for 2012, eligible professional must report the appropriate G-code on at least one claim for a service that appears from denominator between January 1st and June 30th. If a group practice is claiming a hardship they must submit that request at the time they self-nominate to participate in the e-Prescribing GPRO 1 or GPRO 2.

Just very briefly on slide 66, the Physicians Fee Schedule amount paid in 2013 for professional services who are not by through eligible professionals or groups who are not successful electronic prescribers will be reduced by 1.5 percent. Basically if you are a successful electronic prescriber meaning you prescribed at least 25 times and report that to us in 2011 so you would be eligible for the 2011 incentive. You will also be exempt from the payment adjustment in 2013 so that's another reason why folks may want to get started to make sure they are successful in 2011.

So basically a summary on slide 67, 2012 those that are identified as not successful electronic prescribers may be subject to a payment adjustment. Again you got to get your 10 e-prescribing events in if you are individual and again the number varies if you are GPRO before June 30th or you have to report one of the hardship G-codes to avoid the payment adjustment in 2012 which again is prospective. You need a qualified e-prescribing system and again you can look at the qualifications on the cms.gov/e-Prescribing incentive payment Web site.

And basically I think that's it. You can report this measure via Registry but not through avoid the payment adjustment that has come in on claims and I'm going to now turn it over to Molly MacHarris for some information maintenance certification and Dr. (Rex) will be also talking with Molly on maintenance certifications.

Molly MacHarris: OK, thank you Dr. Green, moving on to slide 73 Dr. Green mentioned I will be going over the Maintenance of Certification Program incentive reporting requirements. The Maintenance of Certification Program is an additional incentive that is new for the 2011 program here.

So starting on slide 73, beginning in 2011 physicians who are incentive eligible for the 12 month reporting period for Physician Quality Reporting can receive an additional 0.5 incentive payment and Maintenance of Certification program incentive requirement have also been met.

In order to qualify for the additional 0.5 percent incentive the physician will need to complete the following, satisfactorily submit data without regard to method, on quality measures under Physician Quality Reporting, for a 12-month reporting period either as an individual physician or as a member of a selected group practice and be more frequently than is required to qualify for or maintain board certification and that applies to both participation in the maintenance of certification program and you must successfully complete a qualified Maintenance of Certification program practice assessment.

A Maintenance of Certification Program is defined as a continuous assessment program that advances quality and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism.

Such a program shall require physician to do the following, maintain a valid, unrestricted medical license in the United States, participate in educational and self-assessment programs that require an assessment of what was learned, demonstrate through a formalized, secure examination that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment

to provide quality care in their respective specialty and successfully complete a qualified Maintenance of Certification program practice assessment.

Moving onto slide 75, Maintenance of Certification vendors, Registries, entities will be managing the program for participating physicians. Only those organizations that meet the definition of a Maintenance of Certification Program which I just went over would to self-nominate by January 31, 2011 to potentially become a qualified Maintenance of Certification entity. A listing of the conditionally qualified entities will be posted on the PQRI section of the CMS Web site this spring.

Individual physicians who would like to participate in the additional Maintenance of Certification program incentive do not need to self-nominate. Physicians would need to work directly with the entity or board to complete the Maintenance of Certification required activities during 2011. And the qualified entity or board will submit 2011 information during the February to March 2012 submission period on behalf of physicians.

On slide 76, we have a little bit of information on the criteria that would need to be included in the self-nomination letter. If you go to our Web site <http://www.cms.gov/pqri> spotlight we do have some additional information on the requirements for self-nomination for 2011. We have also issued additional guidance on the more frequently requirement for the maintenance of certification program incentive.

We have received a few questions and we felt that issuing a guidance would help clear those items up and that is available on the overview page on the PQRI Web site and you can find in the download section. And again Maintenance of Certification program incentive self-nomination letters must be received by CMS no later than 5 PM Eastern on January 31st 2011 that's Monday. So please make sure that you send your letters within the next few days so we can receive them by Monday.

On slide 77, we go over a few more reporting requirements. All information must be submitted in a secure format to CMS by a qualified Maintenance of Certification program entity by March 31, 2012, including the eligible

physician's name, the individual National Provider Identifier not the group NPI, the applicable Tax Identification Number or Social Security Number used to bill and receive Medicare reimbursement.

You would need to receive attestation from the board or entity that the information provided to CMS is accurate and complete. We would need to receive confirmation that the board or entity has signed documentation from physician that they wish to have the information released to CMS for their voluntary program. You need to make sure that information is on file and we are looking to receive information from the experience of care patient – patient experience at care service and indication of whether or not the physician has successfully completed a qualified Maintenance of Certification program practice assessment for the year.

Information certifying the physician participated in Maintenance of Certification program for a year more frequently than required to qualify for or to maintain board certification status, including the year the physician met the board certification requirements for the Maintenance of Certification Program and the year that they have participated in it more frequently than required.

We also look to receive information certifying the physician completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify for or maintain board certification, including the year of the original practice assessment or that one is not required for the physician, and the year of the additional practice assessment completion.

Lastly on page 79, the potential 0.5 percent incentive only applies to those physicians who qualify for a 2011 Physician Quality Reporting incentive. The incentive is for a subset of eligible professionals specifically for physicians, it's not for the entire list of eligible professionals and it is only applicable for those physicians who participate in the 12 month reporting option.

The incentive will be paid at the same time as the 2011 Physician Quality Reporting incentive for those who qualify. It will be separately identified on the 2011 feedback report and physicians cannot receive more than one

additional 0.5 percent incentive even if they complete a Maintenance of Certification Program in more than one specialty.

The system will determine incentive payments for group practices participating in GPRO I or II who had Maintenance of Certification incentive-eligible members. If group practice satisfactorily reported Physician Quality Reporting, the group practice will receive an additional 0.5 percent incentive payment based on the allowed charges attributed to group practice members who were found eligible for the Maintenance of Certification Program incentive payment.

And lastly on page 81, if you have any questions you can always contact the QualityNet helpdesk at 866-288-8912. They are available from 7:00 to 7:00 Central Standard Time Monday to Friday or via e-mail at qnetsupport@sdps.org. Those are all of the presentation which we have for today, Jacquie?

Jacquelyn Kosh-Suber: Thank you Molly, Shannon we will take questions now.

Operator: At this time I would like to remind everyone in order to ask a questions press star then the number one on your telephone keypad. When your line is opened please state your organization, we will pause for a brief moment to compile the Q&A roster. Your first question comes from the line of Susan Singer; your line is now open.

Susan Singer: Hi, my boss and I are trying to find on as far as the feedback reports for the PQRI is exactly precisely what he is doing wrong so that he is not getting any checks. I mean I know that they give you percentages but how do I find out exactly what he is doing with his reporting.

Dr. Daniel Green: What you would do is call the Helpdesk and the Helpdesk is capable of going into great details and explaining it to you.

Susan Singer: OK.

Dr. Daniel Green: Have you contacted them?

Susan Singer: Do you have that number?

Jacquelyn Kosh-Suber: Yes, at 1-866-288-8912 or you can e-mail them at
qnetsupport@sdps.org.

Susan Singer: OK, great, thank you.

Dr. Daniel Green: So what the HelpDesk can do is anywhere giving you the basics all the way up to investigating the details, claims, looking at what was reported and stuff like that. In general the biggest gap is just the percentage of applicable cases how much reporting takes place.

It requires 80 percent of applicable cases for individuals measures and 30 for the measured group so just to know for 2011 that percentage of reporting is dropped down to 50 percent so this will be easier but the overall biggest reason people fail to qualify for the incentive is they just don't report on the right number of applicable cases meaning that they are missing cases where they should reporting specification of measures. So they will be able to work you of details and give you the exact situation in your particular case.

Susan Singer: OK, great, thank you very much.

Dr. Daniel Green: You are welcome.

Jacquelyn Kosh-Suber: You are welcome. Next question.

Operator: Your next question comes from the line of (Rachna) (inaudible) your line is open. Please state your organization.

(Rachna): Hi, I'm calling from the American Academy of Dermatology and my question was how are the E-Prescribing penalties being assessed to physicians who are non-participating in Medicare?

Dr. Daniel Green: Well I believe we don't have anybody from the payment side of the house here but basically it's a reduction of one percent sorry but you are saying non-participating only yet what is it? Ninety-six percent as it is.

(Rachna): Yes, but what if they have unassigned claims which they have the patient get payment and then tell the patient themselves?

Dr. Daniel Green: Well, it still applies because the payment adjustment is not limited to participating physicians or those for which payments are assigned but we could – we can try to clarify exactly how that works but in fact a one percent reduction.

(Rachna): Thank you.

Jacquelyn Kosh-Suber: Next question.

Operator: Your next question comes from the line of Regan Daily. Your line is now open.

Regan Daily: Hi this is Regan for the Northern Cardiology and I had a question regards to a specific measure number 202 which is the ischemic vascular disease and on there we have an (inaudible) and cardiologist and they do a lipid profile here in the office and then they are send over for a six months down the road or something.

Are we still allowed to do the same that their lipid profile has been checked when that goes through because there are things such that one was done but then if you look at the second page where it says this specific numerator it says that the results were documented and usually in the statement report they don't document those levels.

Dr. Daniel Green: I'm not sure if I understand exactly what are you saying. You are saying – what does the CPT 2 code say?

Regan Daily: For this particular measure you have to do I just give you the description it says percentage of patients 18 and older with ischemic vascular disease should receive at least one lipid profile within 12 months so then you have all of your numerator which include I should say denominator which include office visit and the placement expense.

So when they are here in the office you know the doctor has that information reported in his service you know when it's also reported in our chart but when they go over to the hospital the physician who is a prime expense which is normally a different physician doesn't usually have that in his direct report and so we just want to make sure that should we be doing two different ones on this same patient or is that we are putting too much into it.

Dr. Daniel Green: So basically if the doctor (inaudible) has my check, they don't have to dictate it in their report this LDL was 160 or whatever but they would need to have a copy of the report and look at the report maybe part of the chart or whatever that's fine but they need to have checked it. If they have checked it they have no idea what patient's lipid values and that they would not have meet the quality indicator for the measures.

Regan Daily: OK, great because there is the option that says that it was not performed but then the patient hadn't had a lipid so we were like...

Dr. Daniel Green: For incentive purpose for that doc it was not performed if they haven't checked.

Regan Daily: Terrific.

Dr. Rapp It's just that they don't have to do a second documentation. It's in the record that...

Dr. Daniel Green: I think there is two different docs in the patient, one for (inaudible) and one for the office.

Regan Daily: So you want the documentation from the initial lipid panel in your chart.

Dr. Daniel Green: You can count one blood test twice but each person would have to have the copy of it. They only dictate in the note or anything it was supposed to be that they looked at it.

Regan Daily: OK, perfect. Thank you for clarification.

Dr. Daniel Green: Thank you

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Julie Sanders; your line is now open.

Julie Sanders: Hi, on slide 61 for e-Prescribing you talk about let's not getting penalized in 2012 and have 100 cases in the denominator. Is that 100 cases for the six months or a 100 cases for the whole year?

Dr. Daniel Green: For the six months.

Julie Sanders: OK.

Dr. Daniel Green: In other words it has to be six. The penalty will be considered for application once you have a list of 100 cases during the first six month for 2011.

Julie Sanders: And is there a number for the whole year then for 2013?

Dr. Daniel Green: No, because the way you will avoid is the for 2013

Julie Sanders: The 200 for 2013?

Dr. Daniel Green: Well, the way to avoid penalty for 2013 in terms of what we've described so far is nearly that if you qualify for the incentive in 2011 then you don't get penalized in 2013. It's possible that we could add some elements to that but we didn't provide any specific numbers like that. If you meet the requirements for the incentive in 2011 then there is no penalty – there is no payment adjustments in 2013.

Julie Sanders: Great, but I have a lot of physicians that only see a handful of Medicare so they wouldn't see 200 for say in 2011 so...

Dr. Daniel Green: They don't need 200 in 2011, they only need a 100. If they have 100 they could be subject to the payment adjustments. Let's say they only had 50, they only have 50 in the first six months they wouldn't be subject to the payment adjustments 2012 however if they chose do the e-Prescribing measure reported on at least 10 people that definitely would guarantee if they can find

another 15 in the second half of the year they would also get out of 2013 from a payment adjustment and they would be incentive eligible in 2011.

So the 100 is to protect people from only having let's 15 Medicare visit in the first six months if they have e-prescribe on 10 of them. It's really to protect those folks but you know there is no thing that you have to have a minimal number of Medicare patients to actually do the e-Prescribe – to actually do the prescribing as long as you have 10 electronic prescriptions.

Julie Sanders: There is no magic number yet for '13?

Dr. Daniel Green: No, it's just again if you have fewer than a 100 in that first six month that fall in the numerator of the measure you would be exempt from the penalty.

Julie Sanders: In '12?

Dr. Daniel Green: In '12

Julie Sanders: Right, I was looking for a way to avoid the penalty for '13 as well Medicare providers.

Dr. Daniel Green: They could e-Prescribe 25 times during the course of the year and now we get them out of their 2013 too.

Julie Sanders: But Tim and Molly are seeing 30 patients a year.

Dr. Daniel Green: I get that but you know the Medicare population in general not every patient of course but tends to take beyond several medications so it's not like seeing a 20 year old that may not need medication.

Julie Sanders: OK, thank you.

Dr. Daniel Green: Thank you.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Sander Buss; your line is now open.

SandraBuss: Hi this is Sandy from St. Luke Physicians Group and I actually had two questions I need you to clarify zero percent performance rate and also my second one is when you go to the Maintenance of Certification program would that involve NCQA way at all for diabetic program?

Dr. Daniel Green: No to the second question, that's a recognition program. It's not an actual board certification like American College of Physicians well I'm sorry like the American Board of Internal Medicine or America College (inaudible).

Sandra Buss: But the boards are also allowing to substitute instead of doing their program, they can use their NCQA's for request?

Dr. Daniel Green: Pardon me.

Molly MacHarris Well NCQA if they want to participate in the maintenance of certification program, they would have to self-nominate as an equivalent entity and if they do that than they could be consider for Maintenance of Certification program entity.

Sandra Buss: OK, thank you and then would you explain the zero percent performance rates?

Molly MacHarris: New for 2011 we are not allowing zero percent performance rate that's only for Registry and EHR based reporting. What we found upon analysis of our Registry data is we had a percentage of zero percent performance rate and we feel this is due to just getting e-Prescribing directly from EHR that physicians didn't actually need to report on this measures so that's why we've enacted the rule of a zero percent performance rate.

Sandra Buss: OK, I understand it now. Thank you very much.

Molly MacHarris: Not a problem.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of (Paula Betty). Your line is now open.

Paula Sardee Hi, what are the requirements for reporting the G8533 for e-Prescribing as faced by the same eligible professional who performed the covered service as the payment code, we are a residency program so our residents have three sectors. They are seen with the physicians, the resident e-Prescribe, they e- Prescribe under their own name but when we bill we bill under the teaching physicians, the faculty physician.

Is that a problem for us because we have a qualified system e-Prescribing system that meets all the qualification for Medicare and the only problem that we were concerned about is the resident is actually e-Prescribing the medication that's a different name than the e-Prescribing compared to how we bill which is under the teaching physicians.

Dr. Daniel Green: As it stands currently say for 2011 that attending physician could bill pen that code to their claim because here she is ultimately responsible for that patient's care. So while I understand resident a maybe writing the prescription for the attending ultimately the patient enable access from resident A's prescription that attendee is medically responsible party. And they would be billing for the services et cetera so they would be able to attend that G-code and get credit for the e-Prescribing event.

Paula Sardee Wonderful, thank you very much.

Dr. Daniel Green: Thank you.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Scott Birth. Your line is now open.

Scott Birth: Yes, thank you, I'm from the Candie's foundation for Medical Care and I have question about practices that may achieve Meaningful Use this year and if they don't participate currently with the e-prescribing how will they avoid getting the reduction.

Dr. Daniel Green: So basically there are two separate and of course we encourage folks to participate in the Meaningful Use program as well as in Physician Quality

ReportingSystem program and to avoid the incentive reductions I'm sorry payment reduction we encourage them to report the e-prescribing incentive. So let me describe it for you briefly how it might work let's say one of your docs decides to do the Meaningful Use program and they attest their three month worth of whatever part of which is the e-Prescribing component sorry the Meaningful Use.

So that's great they would submit their information and that program would determine whether or not they are in fact incentive eligible. Now assuming that they are incentive eligible for Meaningful Use they cannot I'm sorry they are incentive eligible for Meaningful Use under Medicare not Medicaid but under Medicare.

They cannot earn an incentive for the e-Prescribing program at the same time. They can for PQRS but they can't for the e-Prescribing incentive program. They can however get a penalty for not reporting correctly to the e-Prescribing program so you could be successful in Meaningful Use but still get a penalty in the e-Prescribing program so what we encourage folks to do even if they are doing the Medicare Meaningful Use program do report in the first six months that you electronically prescribed at least 10 times for services that appear in the denominator of the measures.

If they do that they will be exempt from the penalty for the e-Prescribing incentive program. They will get their Meaningful Use incentive again if they qualify. And if they want a further report an additional 15 patients in the second half of the year or even in the first half of the year if they want to do all 25. They would further be exempt from 2013 so rule is you can't earn an incentive for the Meaningful Use Medicare and the e-Prescribing incentive program. You can earn an incentive for Meaningful Use Medicaid and earn an incentive in e-Prescribing Medicare program.

Furthermore last thing is you can let's say a patient comes in today collecting for my Meaningful Use and I e-Prescribe something for that patient that can count both in my meaningful and that same prescription would count as one of my 10 required to avoid the payment adjustment by appending that G-code on the claim.

So you can count the unique patients in each I'm sorry for each program the same patients that is but you can't just earn an incentive in those if you are doing Medicare on the Meaningful Use side.

Scott Birth: OK, so practices that plan on achieving Meaningful Use are eligible professionals by the end of the year they still just have the first six months though for the e-Prescribing?

Dr. Daniel Green: That's correct.

Scott Birth: OK, thank you.

Dr. Daniel Green: Thank you.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Sandra McCuen. Your line is now open.

Sandra McCuen: Hi, I'm calling from Pennsylvania Physical Therapy Association and I have a question about individual measure reporting and my question is there a minimum number of patients that must be reported upon and I understand that they have to successfully reported 50 percent of the time but would you get the same potential bonus if you only have 10 eligible patients versus 30 eligible patients.

Aucha Pracharanorong For individual measure reporting there is no minimum number of patients required but if you are talking about measures group then there is a minimum number of people.

Sandra McCuen: My question was on individual so that's the answer I needed. Thanks so much.

Jacquelyn Kosh-Suber: You are welcome. Thank you. Next question.

Operator: Your next question comes from the line of Gary Robinson. Your line is now open.

Gary Robinson: Yes, I'm calling from the New York Heart Center in Syracuse and my question is concerning two of our specialties we have an interventional cardiologist and then an electro physiologist who worked predominately at one of our local hospitals who don't many if any office visit type encounter so they would not be reporting 10 percent of their visits being E&M services that would need the G-codes for e-prescribe. Would these physicians be losing the one percent of their Medicare applicable charges because they would not be e-prescribing and not so to speak?

Dr. Daniel Green: So when you are saying that they don't meet the 10 percent threshold they may 95 percent billing for other codes.

Gary Robinson: Correct.

Dr. Daniel Green: If they don't meet the 10 percent threshold for codes that appear in the denominator of the measure they are not subject to the payment adjustments.

Gary Robinson: OK, good because I know they won't going to getting the increase I just didn't know what was going to happen with the decrease. OK, very good thank you very much.

Dr. Daniel Green: We probably not getting a lot of sympathy about our cold winter woes here from you are we?

Gary Robinson: No, temperature came up to 26 degrees and it ended at 12 so yes we started the day at minus 14 so no sympathy whatsoever.

Dr. Daniel Green: Thank you for the question.

Gary Robinson: Take care, bye.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Debby Robin. Your line is now open.

Debby Robin: Thank you, first of all I'm calling from the American Gastroenterological Association so thank you for the GI example we appreciate that. I had a question about slide 21 the Registry reporting and the 80 percent and eight patients so I want if you could please elaborate on that 80 percent piece. This year it's been you know requirement for 30 patients for 2010 so we are just trying to understand how that would present works in there?

Molly MacHarris: So for Registry reporting for measure group 33 option you could report for the 12 month period for 30 unique patients and all those patients must be Medicare beneficiary and then you could report on a measure group having 80 percent recording rate and you have two reporting period the full 12 months or July 1st to December 31st. And slide 21 refers specifically to the six months reporting option for the measures group that we would need you to report on measures group for an 80 percent reporting rate for Medicare plus fee patients.

Debby Robin: OK, so if you are reporting to the six months you would report 80 percent in that of your patients so...

Molly MacHarris: So it would for at least 80 percent of the applicable Medicare Part B patients.

Debby Robin: OK.

Molly MacHarris: You have to have a minimum of eight patients seen during that reporting period.

Debby Robin: OK. So you have to see eight and report on at least 80 percent.

Dr. Daniel Green: You have to report on at least 80 percent and it has to – that 80 percent number has to amount to at least eight.

Debby Robin: OK, great. Thank you that's very helpful. Option is more for people who don't have 30 patients that they could report on.

Dr. Daniel Green: Right, if you have 30 Medicare patients that's generally the easiest way for folks to meet this measure however if you don't have 30 patients or even if you do you could still report on 80 percent of those patients should do so let's

say you have 32 patients and for whatever reason you missed two patients as long as you report on 80 percent.

So 80 percent of 32 would be 27 patients be a little bit less but actually be 26 patients not only really 25.6 so let's show off with the math. In any case if you reported on 26 of those 32 patients you would qualify under the 80 percent rule even though you had reported 30 patients but that's for one year. If you did the second six months we could use a different example but and it reminds of the GI joke but I'm going to forego it to the national call and Jacquie is waving. But I ask of the (inaudible) I'll just leave it at that.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Harry Selman. Your line is open.

Harriet Selman: Hi, I'm from the University Hospitals Physicians Services in Cleveland Ohio and my question is on our radiology oncologist with e-prescribing. Many times – first time they see the patient that falls within their CPT code range but they don't prescribe for them at that point when they come back the patients come back for their patients is when the physicians prescribe for them and those don't fall in the code range.

Dr. Daniel Green: So do they have radiation oncologist obviously the major part of their services/charges are through the radiation treatment et cetera so they meet the 10 percent directional do you think with that first visit and then the subsequent therapies.

Harriet Selman: It's very possible that they meet the 10 percent with their first visits, yes.

Dr. Daniel Green: So if they do in that instance unfortunately they would be accountable so I mean I am hardly suggesting how should practice or prescribe but if they know the patients is coming back maybe they prescribe the medications so that the patients has them at the time of their next visit. Again I can't suggest for you but they would subject to the payment adjustment if they don't do it with 10 prescriptions.

Harriet Selman: OK, thank you.

Dr. Daniel Green: thank you

Operator: Your next question comes from the line of (Gary Zuni) your line is now open.

(Gary Zuni): Hi, I'm with TMF Health Quality Institute in Western Texas and my question is and you may not be willing to answer but a prescription. The definition of a prescription does that include a refill that comes from a pharmacy or does it have to be something that's written directly from the hand of the prescriber.

Dr. Daniel Green: So that would be something that's electronically prescribed directly from the prescriber so for instance Mrs. Jones comes in and says hey doc I ran out of my atenolol yesterday can you refill it for me, well she may actually have refilled that she could have called the pharmacy herself but if you are actually prescribing station and you actually prescribe it for her that's fine.

If the pharmacy on the other hand you know send you something over that you have to go quick box that says we have refilled for Mrs. Smith that would not necessary count. For one thing many of those prescription refills come in when Mrs. Smith is not in the office. So we got no way to actually send out that e-prescribing is the same thing as if you are on call on a weekend and she calls up and you need to refill or new prescription there is no visit associated with that event.

(Gary Zuni): All right that's one answer and then the associated thing really is and this may be beyond what you are talking but the Meaningful Use is requiring that an eligible professional write prescription that sort of seems to have eliminated a medical assistant from their traditional delegated role of refilling prescriptions, so the definition of an electronic prescription. My original question does a refill count as an electronic prescription from that point of view of having eligible professional write the prescription?

Patricia Holtz The Meaningful Use be eligible professionals are defined differently than they are in the E-prescribing so a medical assistant wouldn't be an eligible professional.

(Gary Zuni): So the medical assistance is not your (setting) I believe program.

Dr. Daniel Green: No they are not but I think partially what Teresa is talking about is the Meaningful Use program has its defined set of criteria. The program while similar are not the same and so you really need to check the requirement for the Meaningful Use program to be sure but currently again for our program and what we are stressing on this call you know that refill again if the docs generate, if the docs generate the refill and the office with patient there could count as one of the e-Prescribing event but if the pharmacy just send over an electronic message hey we need OK to refill this prescription that would not count.

(Gary Zuni): OK, I will have to push through with MU people.

Dr. Daniel Green: Yes, I'm sorry that we can't clarify that more for you.

(Gary Zuni): All right, thanks a lot.

Dr. Daniel Green: Thank you.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of (Terry Aswind) your line is now open.

(Terry Aswind): Hi I just had a question with the measures list like I said a physician could pick like say three measures out of that list and report on. What if we took like four measures out of the preventive group does that count or do they have to stay as the grouping to report on.

Dr. Daniel Green: No you can report this measures individually but remember if you don't report them as a group which is totally fine, you would need to report on 50 percent of all applicable patients and you report via the measures group you kind of get a little bit of path and that's is cast at 30 patients. But in a non-measures group if you just take a few of those measures out of there you have to report on 50 percent of all applicable patients.

(Terry Aswind): OK, is that 30 patients per physicians, 30 patients in our group under our tax id.

Dr. Daniel Green: Unless you self-nominate as a GPRO, a GPRO 2 actually and then it would be dependent on the number of docs in your practice you need to it would be per doc again unless you are GPRO 2 which case we do. There are certain – you wouldn't have to if you are a group of five you wouldn't have to report on 150 patients but I'm not sure the number exactly in front of me I think it's 35 if you are group of 2 to 10 but it could be as many as 50. But you can check those requirements on our Web site on the PQRS Web site by looking under the group before the options.

(Terry Aswind): OK, Thank you.

Jacquelyn Kosh-Suber: Next question please.

Operator: Your next question comes from the line of Stacey Hettiger your line is now open.

Stacey Hettiger: Thank you very much; this is Stacey Hedger for the Michigan State Medical Society. I just have two questions one actually the question was answered before I too was concerned about those who were trying to attest their Meaningful Use as they are being told that they can't participate the e-Prescribing incentive for Medicare if they are doing a Medicare Meaningful Use.

But I have a question you had mentioned that they still could go ahead even report the full 25 the way I'm wondering is there a mechanism so that the system won't generate an incentive payment to them if they qualify with the 25 is my first question. And then my second question is I have a physician's office call me in regards to they don't receive the e-Prescribing incentive payment for 2009 and we believe they have received interest information from the QualityNet helpdesk so I'm wondering where we go from there?

Molly MacHarris: The first question regarding the two incentive programs Meaningful Use and the e-Prescribing incentive program if you meet both program you would receive the Meaningful Use incentive because when you sign out for Meaningful Use first you have to register and then you would go in and attest that you have achieved Meaningful Use.

So when you go in and do that from our perspective that is the indication that you want to receive the Meaningful Use incentive. The only instance when you would receive e-Prescribing incentive over the Meaningful Use incentive you didn't actually meet other criteria of Meaningful Use and you did that you are prescribing incentive criteria.

Stacey Hettiger: OK, thank you.

Molly MacHarris: And then to your other questions...

Jacquelyn Kosh-Suber: For the question with the helpdesk if you give your name and number I can follow up with you over the net because I have to get your HelpDesk ticket information and follow up that with.

Stacey Hettiger: OK, great. My name is Stacey Hettiger 517-336-5766.

Jacquelyn Kosh-Suber: All right, thank you, I'll follow up with you.

Stacey Hettiger: Thank you so much.

Female: All right next question please.

Operator: Your next question comes from the line of Tim (inaudible) your line is now open.

(Tim): My question concerns the 10 percent threshold with respect to avoiding the payment of adjustment would that also be applicable for years 2012 with 2013?

Dr. Daniel Green: We can necessarily discuss 2012 with 13 not because we are trying to particularly secretive but we haven't begin the proposed rule for 2012 or 2013 so I mean the 10 percent was if I'm not mistaken was part of the legislation and

Aucha Prachanronarong. And is associated with e-Prescribing measures but we don't necessarily have to use the e-prescribing measures so...

Dr. Daniel Green: I mean so I'm not sure if you could hear (inaudible) response so it was assisted with the measure and legislation but we don't necessarily have to use the measure going forward so it would be impossible for me to predict what will happen in 2012 and '13.

(Tim): Thank you.

Jacquelyn Kosh-Suber: Thank you, we will take our last question Shannon.

Operator: Your last question comes from the line of Cathy Durum your line is now open.

(Cathy Durum): I apologize that question was answered.

Dr. Daniel Green: All right we will take one more then.

Jacquelyn Kosh-Suber: OK, we will take one more question.

Operator: Your next question comes from the line of (Caroline Roberts) your line is now open.

(Caroline Roberts): Hi, I'm Baystate Medical Practices and I have questions regarding dates. What would be the exact date for the Registry is require to report e-Prescribing and PQRI data to CMS say for any given year but for 2010 and 2011.

Molly MacHarris We receive the Registry data a year I'm sorry in the spring at the end of the reporting year so for our 2010 program you will be receiving Registry data from January to March 31st and we anticipate the same for our 2011 programs. You would be receiving that Registry data January 1st to March 31st 2012.

(Caroline Roberts): OK and that would be both PORS and the e-Prescribing incentive.

Molly MacHarris That's correct, just one more note for e-prescribing reporting for the payment adjustment you cannot report that through a Registry, that has to be reported through claims.

(Caroline Roberts): OK, I actually I was very happy that you covered that material and another thing is we are going for qualified Registry status so my question has to deal with what date does the Registry need to apply to be qualified to report the e-Prescribing and PQRI or PQRS data for any given year. It's usually ahead of time right you have to qualify first.

Molly MacHarris Right, so we would need to receive your letter self-nomination by January 31st the next Monday to potentially include in our list of 2011 qualified Registries. In that self-nomination letter you would need to indicate which PORS measure you would want to report and if you would want to report on the e-prescribing incentive program as well and that self-nomination letter is the first step in a venting process that typically takes a few months so you wanted to be a fully qualified Registry until about this summer of 2011 or potentially later than that.

(Caroline Roberts): OK and I can find that data on CMS Web site like the qualifications the self-nominations.

Molly MacHarris The qualification requirements are listed on the alternative reporting mechanism page on the PORS Web site, it should be in the download sections.

Caroline Roberts: OK, thank you very, very much. I appreciate it.

Molly MacHarris Thank you.

Jacquelyn Kosh-Suber: Thank you everyone for your questions today. If you have any further question that we were not able to answer please contact our helpdesk and calling that helpdesk at 1866-288-8912 and they are available through 7 am to 7 pm Central Standard Time Monday to Friday or you can contact them via e-mail at qnetsupport@sdps.org. Thank you very much Shannon (inaudible) today.

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

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