

Centers for Medicare & Medicaid Services
Special Open Door Forum:
2009 Physician Quality Reporting Initiative (PQRI)

Thursday, February 12, 2009
3:00PM – 4:30PM Eastern Time (ET)
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the 2009 Physician Quality Reporting Initiative (PQRI). This call will be geared to those eligible professionals planning to participate in the PQRI for the first time in 2009 and will cover the basics of how to satisfactorily report the 2009 PQRI quality measures through claims-based reporting.

During this Special ODF, CMS staff will discuss the basics of how to satisfactorily report the 2009 PQRI quality measures through claims-based reporting. Afterwards, there will be an opportunity for the public to ask questions.

Additional Information

For information about the PQRI, including educational products, go to www.cms.hhs.gov/PQRI.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 83501646

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html>

A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning February 20, 2009.

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.hhs.gov/opendoorforums/>

Thank you for your interest in CMS Open Door Forums.

Audio File for this transcript:

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: Natalie Highsmith

Leader: Sylvia Publ

February 12, 2009

3:00 pm ET

Operator: Good afternoon. My name is (Marshanda), 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 PQRI Open Door forum.

All lines have been placed on Mute to prevent any background noise. After the speakers' 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 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Marshanda).

Good day to everyone and thank you for joining us for this special Open Door Forum on the Physician Quality Reporting Initiative, also known as PQRI.

This special Open Door is geared towards those eligible professionals planning to participate in the PQRI for the first time in 2009 and we'll

cover the basics of how to satisfactorily report the 2009 PQRI quality measures through client-based reporting.

For more information about PQRI, you can go to our Web site, which is www.cms.hhs.gov/pqri. And slides are posted on the Special Open Door Forum Web page and on the PQRI Web page under the CMS Sponsored Calls link on the PQRI page.

There is also an email address available for you to send in your inquiries. And the email address is pqri_inquiry@cms.hhs.gov. That's pqri_inquiry@cms.hhs.gov.

Now I will turn the call over to Sylvia Publ out of our Chicago Regional Office. (She) is the Senior Quality Advisor for PQRI.

Sylvia?

Sylvia Publ: Thank you, Natalie.

Good afternoon, everyone. It's my pleasure to present an introduction to 2009 PQRI. And we're going to start with Slide 3.

And just basically giving you an overview of today's presentation, I'm going to place PQRI in the context of what we're doing with value-based purchasing. We'll introduce the concept of PQRI and what we have for 2009, what's new.

Then we're going to go into reporting, discussing the - how to - report PQRI measures and codes, what is the measure, and what are some of these codes. And then we're going to have a little overview of

implementing PQRI and some tips on how to begin. And then in closing, we will discuss some resources.

So, going on to Slide 4, as some of you may have read, value-based purchasing really reflects a policy concern about both cost and quality of care.

As many of you are aware, Medicare is the largest purchaser of health care in the world. We have 12 - over 12 million beneficiaries; this number is expected to grow exponentially as our population ages.

In addition to the expected growth, there is concern about the sustainability of financing for Medicare. In the past 30 years, Medicare spending has risen an average of 9.3% annually, considerably higher than the gross domestic product, which is at 6.5%. And currently, to put things into perspective for you, CMS spends over \$1 billion -- that's billion with a B -- per day in Medicare alone.

And to address some concerns with quality and safety, some of you may be aware of the Institute of Medicine publications on quality and safety. And one of them, a cornerstone, was a report that was published in 2001, Crossing the Quality Chasm. This report highlighted specific gaps in what we know is good care and what actually gets delivered to patients.

We know that beneficiaries do not always receive the care that they need, the quality of the care is not always the highest, and there are significant geographic variation in the amount of services beneficiaries receive that is not necessarily related to their clinical outcomes and, in fact, may expose them to higher costs or additional costs.

Historically, Medicare reimburses for services as long as claims are submitted appropriately and according to administrative and policy regulations. And this is regardless of the quality of those services, or regardless whether those services were appropriate to that patient, or whether it actually led to an improved outcome.

So policymakers are asking the question, are taxpayers getting good returns for the dollars we are spending in health care today?

As a result, CMS is changing its culture and its practice. We see value-based purchasing as the key mechanism with an array of tools to transform Medicare from the current payment system to rewarding quality, not quantity, of services type of reimbursement. We believe that it is (unintelligible) can encourage higher quality and can result in avoidance of unnecessary costs, thus enhancing the value of care.

Going on to Slide 5, to give you a little legislative background and how PQRI was first legislated through (TRHCA), the Tax Relief and Health Care Act of 2006. It established 2007 PQRI, which was a half-year program, the last half of 2007, authorizing a 1.5% incentive that was, at that time, subject to a cap. And it established only claims-based reporting method for eligible professionals of up to three - who submit up to three individual (applicable) measures for 80% of eligible cases.

In 2007, MMSEA, the Medicare, Medicaid, and SCHIP Extension Act, authorized 2008 PQRI, which also had a 1.5% incentive, but eliminated the cap that had been established in the prior program year.

It required alternative reporting periods and alternative reporting criteria for both 2008 and 2009. And so we began to see with this reporting criteria that included the reporting of individual measures,

group and reporting not only through claims but also via a registry-based reporting.

Going on to Slide 6, MIPPA, the Medicare Improvement and Patients and - for Patients and Providers Act, established 2009 PQRI. And for the 2009 program, we see a 2% incentive that was authorized for qualified, eligible professionals, which now also include audiologists; there was no effect on the 2007 or 2008 incentive payments.

MIPPA also requires CMS to post on their Web - on our Web site the CMS - the names of the eligible professionals who satisfactorily reported quality measures for 2009 PQRI. Although it's not statutorily required -- there's an error on this slide -- we are testing EHR submission of quality measures for PQRI during this year.

The statute also requires the Secretary of Health and Human Services to develop a plan to transition to - toward a value-based purchasing program for PQRI Medicare payment for physicians and other professional services. And this report will be due to Congress by May 1, 2010. Also, MIPPA established the E-Prescribing Incentive Program as a separate incentive program from PQRI.

Although similar to PQRI in that the E-Prescribing Incentive Program is also a claims-based reporting program in which you put quality data codes on a claim that is eligible for the measure and you submit them to the carrier, the E-Prescribing Incentive Program is separate, has its own measure of specifications, and will have its own established Web site shortly -- it will have an URL. Right now, it is a section under PQRI, but we are migrating that to a separate Web page.

Going on to Slide 7, Slide 7 is basically a diagram of what I just finished speaking about and shows the growth in the number of measures from 2007 and towards 2010.

And basically, under 2010, we are, of course, going to be delivering information about that. It's regarding PQRI through rulemaking, but you can see how the program has grown from a small program to one that encompasses now over 153 measures.

Slide 8.

PQRI reporting focuses attention on the quality of care. These measures were developed by the provider communities and the professional specialty societies and consumer groups.

We have worked - CMS has also worked with the National Quality Forum and the Ambulatory Quality Alliance and several major specialty societies, including the American Medical Association and National Committee on Quality Assurance, to develop measures that reflect the practices that their members perform for our beneficiaries. They all have good clinical rationale, they reflect good measurement science, and are evidence based.

Flipping to Page 9, we have a number of eligible professionals that can participate in PQRI. These are physicians and other non-physician practitioners who can bill Part B services through the physician fee schedule.

There are a number of entities, however, that are not considered eligible professionals, and we frequently do get some questions about

that. Can rural health clinics, for example, or federally qualified health centers participate in PQRI?

And those - the methodologies under which those entities are paid preclude them from participating in PQRI.

Going on to Slide 10, we have a number of documents on the PQRI Web site. This is one of them. It summarizes what's new for 2009 PQRI. And so I would bring your attention to this particular fact sheet, which summarizes those changes. We'll go through those shortly in this presentation.

Going on to Slide 11.

As I mentioned, 153 quality measures comprise 2009 PQRI; 101 are measures from 2008. And we have, in addition, 52 new measures.

The E-Prescribing measure, Measure Number 125, has been removed from the PQRI program because it has its own incentive payment and its own incentive instructions and its own specifications.

We have 18 PQRI measures that are reportable only through registries, and some of these were deemed only - "registry-only reportable" because of the complexity that we found in attempting to analyze claims-based data to try to determine whether the reporting was accurate for those particular measures. So we have moved those to a registry-only type of measure reporting.

We have measure specifications available on the PQRI Web site. These are on the Measures and Codes Section of the PQRI Web site. You'll find them in the Download Section.

And I would impress - urge everyone to really look at your measures and review those measure specifications when you are selecting the measures that you wish to report. The specifications will give you the instructions for how to report the measure; they give you the codes that you'll need to report. It's all encompassed in the measure specifications manual that is posted on the Web site.

Going on to Slide 12, we have seven measures groups that comprise diabetes, chronic kidney disease, preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care, back pain. The measures for the measures group for back pain are reportable only as a measures group because that is a cohesive measurement, and it's not available for reporting individual measures. And we have - ESRD measures group was removed from 2009 PQRI.

Going on to Slide 13.

For 2009 PQRI - for claims-based reporting of individual measures, we have one reporting period. It's the entire year. We have two reporting periods for the reporting of measures groups and for registry-based reporting. And that is a full year, January through December 31, or the second half of the year, July 1 through December 31.

But again, these half-year reporting periods, which can also be the entire period, of course, 12-month reporting period, only pertain to the measures groups and the registry-based reporting of measures.

Slide 14, criteria for claims-based submission of individual measures. We have several options. You could report between January 1 and December 31. You need to report three or more applicable measures,

or you can report one or two measures if less than three apply to the particular practice.

You must meet the target of at least 80% of applicable Medicare Part B fee-for-service patient claims for one to three measures. Again, if less than three measures are reported, an eligible professional is subject to a measure-applicability validation test. We've abbreviated that as MAV.

And MAV applies - and here you have a diagram for MAV on Slide 15. When less than three measures apply and no other measure is reported, we have a two-step process that basically determine whether they will ask - the question is asked whether there were other measures that the eligible professional could have reported .

And I won't belabor this one too much because it'll take time away from the question and answer period, but there is a written measure applicability validation process available in the Analysis and Payment Section of the Web site that you can read.

And this diagram helps you to understand how the measure applicability validation test is applied. Again, this only applies if you report less than three measures.

Going on to Slide 16, we have criteria for measures groups. There are six options. Three are claims-based options for measures groups, and three are for registry-based reporting.

For claims-based submission of a measures group, the reporting period is a full year, January through December 31, 2009. There are 30 consecutive patients for a measures group, or you can have - you can

select a patient sample that's 80% of the applicable Medicare Part B fee-for-service claims for one measures group with a minimum of 30 applicable patients.

This patient sample can be started any time during the year; the 80% sample obviously has to start early in the year so that you can meet the 80% of applicability. But the 30 consecutive patient sample for a measures group can start at any time during the year.

The reporting period that applies to the measures groups is - our second reporting period is the second part of the year, July 1 through December 31 for a half-year reporting and half - 50, you know, half-of-the-year incentive. And again, for that half year, you must have 80% of applicable Medicare Part B patient claims for that measures group with a minimum of 15 applicable patients.

The criteria for claims-based submission of measures groups is identical to the criteria for registry-based reporting of measures groups except that Medicare Part B fee-for-service patients can be included in the consecutive patient sample for claims-based submission of measures groups.

Going on to Slide 17, registry-based reporting of individual measures, there are two options again -- full year or a half year. And I won't belabor on this slide, but I do want to say that registry-based reporting, if you want to know where the qualified list of registries are, it is on the Reporting Section of the PQRI Web site. And you will find a list of - quite a number of registries that can report on your behalf if you're interested in registry-based reporting.

Okay, so now that we've concluded the options that are available, let's go on to Slide 18. And this is a very simplified diagram of what the PQRI claims-based process looks like.

And starting from the upper left-hand corner, there's a visit - a patient sees an eligible professional, and the visit is documented in the medical record. Documentation of that visit is entered on an encounter form; the encounter form then informs the coding and billing staff to place specific quality data codes on the claim depending on the measures that were selected to be reported.

Coding and billing staff then submit the claim to the carrier MAC. The carrier/AB MAC will provide back to the provider a remittance advice notice. That remittance advice notice will contain the Remark Code N365. N365 will denote to the provider that quality data code on that claim has been passed on or transferred to the National Claims History file. The N365 remark code does not indicate whether the QDC, the quality data code, was accurate for that claim or that the measure that's being reported is accurate.

Line items on the claim that contain a quality data code will be denied for payment by the carrier, but then they pass that information on through the claims processing system for PQRI analysis through the National Claims History file.

Professionals will receive that remittance advice notice that's associated with the claim, and this will contain PQRI quality data code line items and you'll be able to identify them on your remittance advice. And please do look for the N365, which denotes that this procedure code "is not payable; it is for reporting or information purposes only."

The information is then available to the analysis contractor from the National Claims History file. The analysis contractor, when they conclude analysis, will provide a confidential feedback report that will be available through a secure Web site.

The analysis contractor, for those who are eligible for the incentive payment, will then inform the carrier/AB MAC to - well in this case, the MAC, to pay the incentive to the eligible professional who met eligibility for the incentive.

Going on to Page 19 - Slide 19, there is a list of 153 PQRI measures that also includes the measure developer name and their contact information and the type of reporting method whether it's claims-based or registry-based, and that list of PQRI measures is available and you have the URL in front of you.

So we have reporting of individual measures via claims, we have specifications for those in the PQRI measures Specifications Manual for Claims and Registry Reporting and Release Notes.

On the Measures and Codes page of the PQRI Web site, you also have the 2009 PQRI Implementation Guide. For those of you who are new to PQRI, I strongly recommend that you read the Introduction in the Specifications Manual, and then jump into the Implementation Guide because that guide will walk you through everything you need to know about how to begin to report. And it also delineates for you some of the reporting principles that are important for you to know when you're submitting your claims.

We also have reporting of measures groups via claims, and support - materials that are supporting that are the 2009 PQRI Measures Groups Specifications Manual and Release Notes and Getting Started with 2009 PQRI Reporting of Measures Groups.

In addition, there is a sample claim that describes for you how to report a measures group. It's a 1500 format sample. You could translate that into the 837 equivalent, but it does break it down for you as to what are the areas in the claim that you need to watch out for for a measures group.

Going on to Slide 20, again, more resources.

On the Reporting page of the PQRI - Section of the PQRI Web site, we have registry-based reporting of individual measures and registry-based reporting of measures groups. And the list of qualified registries you'll find there.

You will also find in the Education and Resources page MLN Matters articles, fact sheets, tip sheets, the 2009 Patient-Level Measures list.

We are continually adding to the PQRI Web site. We are in the process of archiving 2007 and 2008 material that will still be on the Web site and available to you, but '09 will be the focus for the Web site. So you'll see over the next couple of weeks how the material on the Web site is going to change somewhat.

I do want to point out the 2009 PQRI Patient-Level Measures list, if you are considering starting to report - considering beginning reporting the PQRI and you haven't selected your measures yet, do look at the

2009 PQRI Patient-Level Measures list. This list is a list of measures that require only one-time reporting per patient per NPI.

I do want to take a moment now to stress that the NPI is important. The individual NPI must be in the rendering provider ID field for the claim to count. So those of you who are new professionals and do not have your individual NPI yet, you need to obtain that first before you can begin to submit quality data codes on your claims.

Going on to Slide 21.

During our analysis of 2007 PQRI data and 2008 PQRI data, we have seen some recurring errors that are very common. And I'm going to be pointing some of these out in the next few slides, but one of the things that we see - that we have seen frequently is that claims sometimes are submitted for a zero dollar amount. And a claim with an entire zero dollar amount will be rejected.

The CPT Category II codes or G-codes, these are quality data codes that supply the numerator must be reported on the same claim for the same beneficiary on the same date of service for the eligible professional.

The diagnoses that are reported on the base claim will be included in PQRI analysis. So we don't require specific sequencing of any of the diagnoses, but we do require that if you are going to report a measure, that the diagnosis that's eligible for the measure denominator appear on the claim.

Claims may not be resubmitted simply to add or correct QDCs. And we have seen claims that have come in when someone forgot to add

the quality data code and simply just submitted a claim with the quality data code on it. Those will be rejected.

Quality data codes must be submitted with the line item charge of zero dollars at the time the associated covered service is performed. So when you're billing for the performance of your covered service, that is the time to submit the quality data code. If the billing system does not allow a zero dollar line item charge, a nominal amount can be submitted, such as a penny.

Again, the Submitted Charge field cannot be left blank, and the entire claim cannot be a zero charge.

Finally, we've made this point before, but you will receive a remittance advice and it is important for you to look at your remittance advice on a regular basis so that you can ensure that you get the N365 for each quality data code submitted.

We have found in the past that folks have not looked at the remittance advice and found out too late that there was a problem with either the billing service or the clearinghouse not passing the codes on to the carrier, and when we looked at the remittance advice, we did find that, indeed, they did not have an N365 and the quality data code did not appear on the claim.

Going on to Slide 23, this is a CMS 1500 format claim sample. This is available in the Appendix to the Implementation Guide that's available on the Web that I mentioned before. You have the URL here as well.

But basically, this is a patient that is seen for an office visit, 99213. The provider is reporting several measures related to diabetes, coronary artery disease, and urinary incontinence.

And so you will see listed - underneath the CPT 99213, you will see line items containing all of those quality data codes. These are for Measures 2, 3, 6, and 48.

Please note that the sequencing of the diagnoses is not something that we require, but the primary diagnosis, of course, as you all know, should be the diagnosis that supports the service that was billed. The diagnosis that supports the measure that you're reporting can appear as either the primary or the secondary or any other numbered diagnosis on the claim.

Also, we'll draw your attention to the Diagnosis Pointer field. The Diagnosis Pointer field does have to point to the diagnosis that relates to that measure. As you will see on this claim, there are - all the quality data codes do have a zero dollar amount, and all the line items have the rendering physician individual NPI in Field 24J or the 837P equivalent.

Going on to Slide 24, let's look at what PQRI looks like when it's in practice. We have a Mr. Jones patient who presents to an office - for an office visit with Dr. Thomas. Mr. Jones has a diagnosis of diabetes. And we set up a number of steps here that could flow for PQRI.

In this case, we're talking about reporting of the measures group and so for Step 1 Dr. Thomas select diabetes measures group as a PQRI reporting option. The reporting period is one that begins January 1,

2009, and the HCPCS code G8485 is the code for that particular measure.

Dr. Thomas reviews specifications - backing up a little bit, the G-code G8485 tells CMS that this is a claim for which we intend to report a diabetes measures group on this patient who is in our measures group sample.

Going on to Step 2, Dr. Thomas reviews the specifications for six measures in the diabetes measures group to identify measures applicable to Mr. Jones. Dr. Thomas then submits the appropriate CPT Category 2 code for the diabetes measures group.

Step 3, Dr. Thomas reports 30 consecutive diabetes patients meeting the denominator criteria starting with Mr. Jones, who is Patient 1 out of a 30 consecutive by-date of -service measures group.

If all measures in the group are performed, the provider instead of reporting individual diabetes measures, they can report, and this is new for 2009, the diabetes measures group composite G-code, which means it's the "I did it all measures group." So you don't have to report the individual measures.

Alternatively, if a situation arises where the physician can't report all those measures, perhaps there's an exclusion that applies to that patient then the composite G-code cannot be used.

Going on to Step 3B, as an alternative to 3A, Dr. Thomas reports on at least 80% of all the diabetic patients that he sees during the reporting period that meets denominator criteria for applicable diabetes measures.

Again, if all the measures in the group are performed, physician can report that diabetes composite G-code.

Going on to Slide 25. Again, this is an example of the measures groups reporting where you're indicating to us the beginning of a measures group patient sample, consecutive patients by date of service and this is G8485.

The measures group specific G-code that is submitted on the first diabetic patient, which this is the example for, denotes to us that they're meeting the denominator for one or more measures within that diabetes mellitus measures group.

Submitting the G8485 starts the count of consecutive patients for diabetes measures group.

And so the staff would then review the remaining diabetes measures within the group and report the quality data codes for each of the applicable measures unless of course they did everything for the measures group in which case they could report the composite G-code.

Okay. Going on to Slide 26, how do I begin with PQRI? Well the first step would be to gather information from the PQRI Web site, and this would be from both pages that we've mentioned before, the measures and codes page, there's educational resources section within the PQRI Web pages and there's also the toolkit Web page available.

You can also gather information from other sources such as your own professional society or the American Medical Association who does have data collection worksheets and our toolkit page has a link to the

section in the AMA Web site, where you can find data collection worksheets.

These are suggestions only. We don't require that you use data collection worksheet.

Then reviewing the list of measures and the specifications you determine and select the measures or the measures group. You also select the reporting method, the reporting period and the date that you want to begin.

Again, there are a number of sections in the PQRI Web site. They are rather intuitive, so don't be concerned that there are so much information. We have an overview page that gives you an overview of PQRI.

We have a spotlight page now that will highlight for you what's new on the Web site and the date that it was new, we have a statute and the CMS Sponsored Calls page which I'm sure most of you are familiar with if you're on this call. The CMS Sponsored Calls page will give you the materials that we use on all our national provider calls and open door forums. And it'll give you the date and registration instructions for upcoming calls.

We have a statute and regulations program instructions page where we post information about the statutes that are relevant to PQRI. Eligible Professionals page lists the eligible professionals, the measures and codes section of the Web site, it has all the specifications and the implementation guides that you need for reporting both individual measures and measures groups.

The Reporting page will give you the registry information and as we develop information about electronic health record submission, it will be posted there.

The Analysis and Payment page contains the measures applicability validation document that I mentioned before if you are reporting less than three measures.

Again, on that page, there will be information about payments, how to obtain a feedback report when the incentive payment will be coming out, et cetera. So you'll find that there.

The Education and Resources page was mentioned, the Toolkit page, and we have FAQs on each of the Web sections so you can search for frequently asked questions on any page on the PQRI Web site.

Going on to Slide 27, some considerations about measure selection and the reporting method.

Consider the kinds of clinical conditions that are usually treated, what are the most common diagnosis, most common types of care that are delivered? Is it office-based practice? Is it preventive care, chronic care, acute care as in a surgical-based practice, setting in which care is usually delivered? Is it in the office setting or in the emergency department or the surgical suite?

Consider what are your quality improvement goals for 2009, for the patients that come to the practice what aspect of care do you want to focus your quality improvement efforts on.

Review the list of measures, determine which measures apply most frequently to the practice's, Medicare fee-for-service patients.

Medicare advantage patients are not included in PQRI typically, so you are focusing on Medicare Part B patients.

There are many Medicare measures that require one-time reporting per patient per NPI or eligible professional. So take a look at that patient level measures list.

Review the measures specifications manual, select your measures carefully, make sure you understand what - how you're reporting. There are reporting instructions listed on the specs. Look at how - what the coding is, look at how the frequency of the reporting is. All of that is included in the reporting instructions on the measure spec.

Select the reporting method. You can select either reporting through claims or reporting through a qualified registry. Each of these methods include multiple reporting options for each method of reporting.

We have a 2009 PQRI participation decision tree that will help you decide which method would work best for you. You can walk through that tree - that helps you a lot. That's available in the Implementation Guide as well as in the Appendix.

Going on to Slide 28. Preparing to participate in PQRI. Ensure your practice's billing software and clearinghouse are ready to capture all of the codes associated - and associated modifiers that are used for PQRI for the measures you've selected. Discuss carefully with your vendors.

We have found too frequently that those eligible professionals who never talked to their billing software or clearinghouse and thought that their claims were being submitted with those quality data codes on them in fact did not arrive at the carrier with those codes. Don't wait until the end of the year to find this out.

Read and discuss with staff. Reporting principles with classifications for each of the measures selected for PQRI reporting, and develop a process within the office for concurrent data collection so that the physician can quickly circle or check off the quality data code that he wants reported for a given patient.

And again regularly review the remittance advice notices that you receive from the carrier MAC to ensure you're receiving that N365 remark code.

Going on to Slide 29, let's look at some of the - of what the definition is of a measure.

A measure is basically a fraction. It has a numerator. The numerator is typically expressed as a CPT II code or temporary G-code. These codes describe the clinical action that's required for performance.

The denominator is expressed in ICD-9 diagnosis and CPT Category 1 codes and they describe the eligible cases for which the clinical action was performed. In other words, the eligible patient population that was defined in the denominator specification of the measure.

So how does this translate?

Going on to Slide 30, the quality data code translates whether a clinical action was met or it was not met and possibly not met due to documented allowable performance exclusions. And there are specific modifiers that are used in PQRI and CPT Category 2 codes to denote when those allowable exclusions are available or that the measure requirement was not met and the reason is not documented or is not consistent with an accepted performance exclusion.

We have an 8P reporting modifier that helps to report when you meet with those circumstances.

Going on to Slide 31. Again, we mentioned we have unique modifiers that can be used with CPT Category 2 codes only. They are not available for use in CPT Category 1 codes.

These are 1P the performance exclusion modifier, which allows you to report when you can't perform that clinical action due to medical reasons, or 2P, you can't perform the clinical action due to patient reasons, possibly the patient refused, or 3P, the performance exclusion modifier used is due to system reasons. You may not have the equipment or you may not have the particular drug available to you if that is the measure.

One or more exclusions may be applicable for a given measure. There are certain measures that have no applicable exclusion at all, so you do need to refer to the measures specifications to determine which exclusion modifiers are allowable by a measure.

Going on to Slide 32, the performance measure reporting modifier. This modifier was created to facilitate the reporting of a case that could be drawn into a measure because you have a diagnosis and a

CPT Category 1 code that is consistent with a particular measure that you wish to report, but the patient for various reasons is not eligible for that clinical action.

And so the 8P reporting modifier allows you to get credit for reporting not for performance when you report or submit a QDC with that modifier.

Some measures have a performance time frame, going on to Slide 33. The performance time frame is related to the clinical action and it's really distinct from the reporting frequency.

So for example, a measure might say lab test should be performed within 12 months or a lab test should be performed annually or another measure might require you to report the most recent results like for example in diabetes measures, we have the most recent results of a hemoglobin A1c test.

You do not need to have repeated that test. You can look back in the medical record and see if the test was performed within that time frame and document the results within the range that the measure allows you to report.

Going on to Slide 34, again, measures have a reporting frequency - how often, am I suppose to report this? These vary by measure. Depending on the measure you may report it one time or you may report it once for each procedure performed or report it for each acute episode or report for each visit.

Slide 35, we've mentioned this in prior calls. We have a 2007 PQRI experience report. This report is available as a download on the overview page.

And the report pretty much summarizes most of the common problems that we found when analyzing 2007 PQRI data.

Twelve percent or a little more than 12% of claims came into the carrier with the missing NPI. We have almost 19% had incorrect HCPCS code. In other words, you were reporting a measure for a CPT Category 1 service, but that CPT Category 1 service was not listed in the denominator for the measure you're trying to report. We have almost 14% with incorrect diagnosis code.

Incorrect diagnosis code meaning that that particular diagnosis did not match the measure that you were trying to report, and 7% had both incorrect HCPCS procedure code, CPT 1 service code for example would be incorrect and the diagnosis code was incorrect. And then finally, 5% all line items on the claims were quality data codes only.

I draw your attention to the experience report because due to the - some of the analytics that were applied at the time for 2007, we will be rerunning and fixing the analytics, of course, on the back-end and rerunning the report for 2007. The rerun will be completed and feedback information will be available in the fall about that rerun.

But I want to alert you to the report because it pretty much delineates for you the kinds of errors that we see when folks are submitting in 2007.

Going on to Slide 36, again, Slide 36, some common errors that we continue to see with current submissions.

We still have claims coming in without an individual NPI in the rendering provider ID field. We have some eligible claims that we would expect you would have reported on, but you somehow were missed and so they have no quality data codes on them.

We have some eligible claims that were submitted but were submitted with only quality data codes on them. In other words, there's no denominator information such as the diagnosis or CPT1 service code on the claim.

And lastly, we have an eligible claim with quality data codes for a measure, but the diagnosis is incorrect, the surgical procedure is incorrect on the claim for the measure reported or the age or gender is mismatching with the measure specification.

And I do want to draw your attention to a few of the most common types of errors on the most common measures that we see -- osteoporosis, perioperative care measures, stroke and rehab measures, diabetes, some cardiology measures, the medication reconciliation measure -- all had - tend to have some higher error rates.

Antidepressant medication, fall risk assessment, advance care planning, and some of the ophthalmology measures were not well understood and so we found additional higher than expected error rates on those.

Lastly , what are the benefits of participating in PQRI? Well one of the benefits is that you can receive the confidential feedback report that will support your quality improvement efforts.

And by that, we mean that there are practices that have learned through their participation in PQRI that they really needed to change their office practice not for the accommodation for PQRI but to better accommodate the patient.

You can earn a bonus incentive payment. You can make an investment in the future of the practice that's prepared you for higher bonus incentives and we've seen that the incentives have grown from last year to this year.

You can prepare for when we get into the value-based purchasing or pay-for-performance phase of quality reporting.

And lastly, you can prepare for public reporting of performance results, although we only report - at this point public reporting is based on participation in PQRI. In 2009 we will be publishing after the conclusion of the '09 program, those who successfully participated in PQRI.

So learn now before pay for performance is in place, you can learn now without much risk. You could be ready in the future and we anticipate policymakers to continue and add to pay for performance as we go forward.

Going on to 38, this is a screen shot of our Web site. Slide 39 continues with a screen shot where you can see, where you can search frequently asked questions - this is on the Education and Resources page. You can sign up for the Open Door Forum LISTSERV or the physician LISTSERV.

And going on to slide 40, these are a number of resources. These URLs are active where you can find additional information about PQRI, about quality initiatives in general for CMS.

There is information about the December 9, 2008, issues paper on the development of a plan to transition towards value-based purchasing. Some of you may find that document quite interesting. Also included is where you can find information from our Open Door Forum.

And 41, here is information available from external resources, the American Medical Association, NCQA, the National Committee on Quality Assurance, the National Quality Forum, the Medicare Payment Advisory Commission that makes recommendations to Congress about payments in Medicare, the National Academies Press has a number of read online books as well as you can order books that are specifically targeting quality in healthcare.

The Pathways to Quality Health Care Series is an excellent series on performance measurements and improvement.

And going on to the last slide, 42, if you've got questions about PQRI in general or E-Prescribing, contact the carrier, if the carrier can't answer the questions, they do have resources where they can get the answer for you, or you can contact your regional office, or you can submit a specific query to the PQRI mailbox, which is ppri_inquiry@cms.hhs.gov.

So this concludes the presentation for today and I'd be happy to take on some questions.

Natalie, if you'd be so kind.

Natalie Highsmith: Okay. Thank you, (Cynthia) - Sylvia, I'm sorry, I keep calling you (Cynthia), it's Sylvia.

(Marshanda), we're ready to go into our open Q&A portion of the call. If you can just remind everyone on how to get into queue to ask their question. And everyone, please remember when it is your turn to restate your name, the state you are calling from and what provider or organization you are representing today.

Operator: Thank you so much.

As a reminder, if you would like to ask a question, please press star and then the number 1 on your telephone keypad.

Your first question comes from the line of Leslie Witkin. Your line is open.

Leslie Witkin: Hi. This is Leslie Witkin at Physician's First in Orlando, Florida.

I have a large group of cardiac surgeons and the specific question is related to physician assistants. The physician in the practice only provides services for assistant that surgery using the (AF) modifier. And in the 2007 feedback report, they didn't get a bonus although it listed that the specific measures like for perioperative care and internal memory artery were measures that they had an opportunity to report.

I guess I wanted to clarify the FAQ on the PQRI site 9040 specifically says that if assisted at surgery modifiers were used 80, 81 or 82 that those claims would not count. It seems to me as though a physician

assistant just doing assisting at surgery does not have an opportunity to get the bonus, is that correct?

Sylvia Publ: Yes, that is correct.

Leslie Witkin: Okay.

Sylvia Publ: Those claims are - those modifiers cause claims to not be included in PQRI.

Leslie Witkin: Okay, that's what I thought.

Can I just ask one other quick question? In the measures group reporting, let's just take the diabetes measures group, if the doctor sees the patient today and has complied, let's say, with Measure Number 1 in the group and reports the QDC code for that measure, and then, the next time the physician seems to - sees the same patient, perhaps, at that time, the other measures in the group Number 2, 3, 117, 119 and 163 have been met, could that physician at that point then report the composite G-code?

Sylvia Publ: No, because you already had started the individual reporting of those measures.

Leslie Witkin: So the composite G-code can only be used if all of the measures in the group were met at the time of that one patient encounter?

Sylvia Publ: That's correct.

Leslie Witkin: Okay.

Sylvia Publ: And that's what the definition of that G code is.

Leslie Witkin: Okay.

Sylvia Publ: All are met today.

Leslie Witkin: Okay thank you.

Sylvia Publ: Uh-huh.

Natalie Highsmith: (Marshanda), I just wanted to remind everyone again that we do have a large number of participants on the phone lines and if you do have a question or a comment, I ask that you please keep your comments to two or your questions to two and if you have more that you get back into the queue to state your comment or ask your question, so we can quickly move through the questions in the queue.

Next question, please.

Operator: The next question comes from the line of (Rachel Kane). Your line is open.

(Rachel Kane): Hi. We have two quick questions, the fluoroscopy measure, Measure Number 152 about documenting exposure time.

Many of those CPT codes that are included in that denominator do not necessarily require the physician to have used fluoroscopy and there is not a measure - there's not in the exclusion measure that say fluoroscopy - there's not in the exclusion code that allows you to document that fluoroscopy was not actually used on this CPT.

((Crosstalk))

Sylvia Publ: Yes. Where that that situation occurred with some of those measures for radiology and we are working through that with American College of Radiology and the American Medical Association, you will be getting announcement about that.

(Rachel Kane): And until then, what should we use as a code for a procedure where fluoroscopy was not used?

Sylvia Publ: You could use the 8P modifier.

(Rachel Kane): All right thank you. And then, the only other question was, we received some money after the 2007 from the Medicare Advantage or Medical Replacement Plan, and yet we knew that we did not need to be submitting measures on those claims, but is there a reflection with them that we are or not providing quality then, or is there any advantages to us routinely putting PQRI codes on those other types of Medicare plans?

Sylvia Publ: No. There are circumstances where - for example, on a Medicare fee-for-service - Medicare Advantage private fee-for-service plan might consider (for parity) purposes that they should pay you a bonus if you were eligible for a bonus in 2007. Were you eligible for bonus in '07?

(Rachel Kane): Yes. And that's what we're wondering, did we get that bonus because we earned it through the general Medicare not because some codes slipped through on their claims?

Sylvia Publ: Yes. The Medicare Advantage Health Plan decides whether or not they're going to pay an incentive if you qualify for the incentive for the traditional fee-for-service patient.

(Rachel Kane): Okay.

Sylvia Publ: There is an FAQ out there that does explain Medicare - if you search Medicare Advantage or just Advantage on the FAQs, you'll find that FAQ - I don't have it at my fingertips now, but it's rather complex. But it does explain how it is that you could come up with a check, they are a rather small checks I believe.

(Rachel Kane): Okay.

Sylvia Publ: But they do apply to certain of the patients that you saw, and it's based on your billing.

(Rachel Kane): Thank you.

Sylvia Publ: You're welcome.

Operator: Your next question or comment comes from the line of Tamara Carey. Your line is open.

Natalie Highsmith: Hello.

Tamara Carey: Hello.

Natalie Highsmith: Do you have a question?

Tamara Carey: Hi. Yup. This is Tamara Carey with the SVA Healthcare Services.

Similar to a previous question, we bill for a large number of radiology clients, and then our particular question we have within a lot of our groups on radiologists who sub-specialized, in other words, they're interventional radiologists.

So, although radiology does have four measures available to them this year, some of them don't apply or two of them don't apply to our IR docs. Can they choose a different measure from a different - even though I know you don't specialize them with a different specialty category as long as they have three measures?

Sylvia Publ: I think that you need to determine how those measures fit into the practice of those radiologists. If they're interventional radiologists I would suspect that some of their surgical procedures would apply to perioperative care measures?

Tamara Carey: Correct.

Sylvia Publ: Is that what you're asking because they use perioperative care measures?

Tamara Carey: Right. Something that would apply to what their...

((Crosstalk))

Sylvia Publ: Yeah. Just take a look carefully at the surgical procedures that are included in the denominator for the perioperative care measures.

Tamara Carey: Okay.

Sylvia Publ: That they can certainly be available to them for that.

(Dan Green): This is (Dan Green) in Baltimore.

Any measure that the eligible professional feels applies to his or her practice and they had to provide services that appear on the denominator would be appropriate for them to report on.

Tamara Carey: Okay, that's what we thought. Thank you.

Sylvia Publ: You're welcome.

Operator: Your next question comes from the line of (Carmella Naschreiner).
Your line is open.

(Carmella Naschreiner): Hi. My name is (Carmella Naschreiner). I'm from Pittsburgh UPMC Health System in Pennsylvania.

We have a question about Measure 121, where it is CKD, chronic kidney disease and they're asking for laboratory testing in order to - at least during once - during the 12-month reporting period and that would be January 1, 2009, through 12 of 2009, but what if they just haven't done in November or December of '08, with the ones to repeat the labs or used 8P or could we use lab values from 2008 like the last quarter of 2008?

Sylvia Publ: Yes. I'm familiar with your question, (Carmella), and I need to research that with the measure developer.

(Carmella Naschreiner): Okay.

Sylvia Publ: Because I don't believe it's our intent that we would want them to repeat within three months, but I...

(Carmella Naschreiner): Right.

Sylvia Publ: ...I think that there may be - the language might not have been as clear as it could have been on that measure spec, but I will get back to you on that.

(Carmella Naschreiner): Okay. The same with the - can I just send you the two other questions, or should I just wait for those...

((Crosstalk))

Sylvia Publ: Yes. Wait for those because I'll answer all those, yes. Thank you.

(Carmella Naschreiner): Thank you very much, Sylvia.

Sylvia Publ: Thank you. You're welcome.

((Crosstalk))

Operator: Your next question comes from the line of (Linda Commesso). Your line is open.

Sylvia Publ: Hello. Do you have a question?

(Linda)?

Operator: If you'd muted your line, (Linda), would you please unmute?

Sylvia Publ: Hi, (Linda).

Linda Commesso: I think we're all set. Thank you.

Operator: Your next question comes from the line of (Karen Finetti). Your line is open.

(Karen Finetti): Hi. (Karen) from Dr. (unintelligible) Office. And I have a couple of questions.

My first question is more a podiatrist office, so if I'm understanding correctly, we're only allowed to use the claim base measures, not the group?

Sylvia Publ: That's correct because there are - there's no measures group that applies to podiatry unless it's a perioperative care measures group.

(Karen Finetti): Okay. So what G codes will we be able to use under the claims-based measures?

Sylvia Publ: I believe you've got podiatry measures within the 153 measures.

(Karen Finetti): I have the measures but I don't know what G codes you would use, like where would I find the...

((Crosstalk))

Sylvia Publ: Oh, where do you find the codes to report?

(Karen Finetti): Yes.

Sylvia Publ: The codes are available in the 2009 PQRI Measures Specifications Manual. You can download that manual and just print out the specs for those particular measures you're interested in and you can find that in the measures and code section of the PQRI Web site.

(Karen Finetti): Okay. And then, my next question was the data sheets that I see samples of out there, are those just - most of them are just like - they say diabetes on them, are we suppose to make our own specific form?

Sylvia Publ: There are data collection worksheets that the AMA has published on their Web site and you can - there's a direct link from the PQRI toolkit page.

If you scroll to the bottom of the toolkit page you'll see that link to an external site and that's the link to the AMA site. And you can find by your measure that you're selected you can print off the data collection worksheets that they have available if you want to use them.

(Karen Finetti): Otherwise, we can just charge it in our charge notes?

Sylvia Publ: You can do that. You can create your own.

(Karen Finetti): Okay.

Sylvia Publ: We don't require that you use one. It is helpful to have one. Practices that have either created their own or use - a specialty society, for example, might have created one tend to find them much easier to use.

(Karen Finetti): Okay thank you.

Sylvia Publ: As long as they're accurate, you know, why would you use a cheat sheet that's inaccurate.

(Karen Finetti): Right.

Operator: Your next question comes from the line of (Linda Juengel).

Please remember to restate your name, state and organization, please.

(Linda Juengel): Hi. This is (Linda Juengel) Office. We're calling from Radiation Medical Group.

And we are group of radiation oncology physicians and the patient - we're reporting on 102, 104, and 105 for prostate patients. And it's supposed to be reported once per episode and an episode is considered a course of treatment, but often multiple physicians see that patient during the course of treatments. So I just wanted to confirm that we should be reporting for that patient for each of those physicians that they're seeing by multiple physicians?

Sylvia Publ: Yeah. If you are reporting PQRI, it is as an individual physician or Eligible Professional Reporting Program.

(Linda Juengel): Okay.

Sylvia Publ: So when that patient is seeing a number of physicians during that episode, you need to ensure that their individual NPI is on that claim.

(Linda Juengel): Okay. So that doesn't throw up the statistical information that you guys are putting together because that would seem like for one patient,

for one course of therapy the answers are being given multiple times, the same answers are being given multiple times.

((Crosstalk))

(Dan Green): Measuring the provider's performance is not necessarily the patient's performance.

Sylvia Publ: Right.

Linda Juengel: Okay.

(Dan Green): They are trying to ensure that the provider is doing the proper quality actions.

(Linda Juengel): Okay. Is there any issue if we over-report, I mean for instance, if we report more than once per episode for a patient?

Sylvia Publ: No. Over-reporting won't hurt you. We'll only be counting one per individual eligible professional.

(Linda Juengel): Okay, all right. And the only other question I had has to do with the (NC) error report that we received or we've been receiving. It actually indicates that there is an error on our PQRI codes and it's indicating that payments on adjustments will not post, but then when we get the EOP it does show them process with N365 or whatever that N code is. Is that the way it's supposed to work?

Sylvia Publ: I believe your (NC) error report is your billing software?

(Linda Juengel): Yes.

Sylvia Publ: Is that correct?

(Linda Juengel): Yes.

Sylvia Publ: You would have to discuss that with your billing vendor why you're getting an error report there.

(Linda Juengel): Okay.

Sylvia Publ: But if you are confirming that your remittance advice or (EOB) has the N365, then that's telling you that the carrier did receive that quality data code.

(Linda Juengel): Okay, okay.

Sylvia Publ: It won't tell you whether it's right or whether you did it on an eligible case, but it will tell you that that quality data code for a zero charge is going on through to the National Claims History file.

(Linda Juengel): Okay. I guess - yeah. Okay. The last thing is do - are there any CEU credits for this?

Sylvia Publ: For this presentation?

(Linda Juengel): Yes.

Sylvia Publ: Well, I don't believe that we have CEUs or CME for any of our provider calls.

(Linda Juengel): Okay.

Natalie Highsmith: Okay. Next question, please.

Operator: Your next question comes from the line of (Jan Mahlman). Your line is open.

(Jan Mahlman): Yes. Hello. My name is (Jan Mahlman). I'm calling from the State of New Jersey from Whiting Medical Associates. We're an Internal Medicine Practice, and we're doing the preventive measures of the Pneumovax, the influenza and the colorectal cancer screenings.

My question is, I've looked over the measures and they don't state there has to be a specific diagnosis for this.

Sylvia Publ: No.

((Crosstalk))

Sylvia Publ: Those measures don't have a diagnosis attached, you're correct, but the diagnosis that you would point to on the claim, for example, would be the primary diagnosis for which that visit was made.

(Jan Mahlman): Okay. So the patient came in for the (CID) or diabetes or whatever they came in for...

Sylvia Publ: Uh-huh.

(Jan Mahlman): That primary code would hit all of our G codes.

Sylvia Publ: Right.

(Jan Mahlman): Okay. Now, here is my second question and this is only because - and I truly do care about my doctors.

I made a cheat sheet for them and they basically use the preventive measures the one that you're supposed to use once and say, "Hi, I'm going to start utilizing this," they've used it on everybody. I mean, we're having meeting tonight. I'm ready to meet them (to follow up), is there any way - do we just start now, you know, after we have our meeting tonight and say, "Use this only once," and then we're going to start again? I mean...

Sylvia Publ: I'm a little confused about your question only because you said that you are reporting only three preventive measures.

(Jan Mahlman): Right. But on...

Sylvia Publ: So you're reporting them as individual measures.

(Jan Mahlman): Yes. We are; however, it states that on the very first patient of each for preventive you have to send the one G code through saying that we're going to start using preventive measures and then, use your individual measures?

Sylvia Publ: You're mixing up your specification.

(Jan Mahlman): Okay.

Sylvia Publ: That G code that you're referring to is the starting G code for a measures group.

(Jan Mahlman): Okay.

Sylvia Publ: If you're not reporting via measures group, then you - don't need to use the measures group specs, use the individual reporting specs.

(Jan Mahlman): Okay. So we don't have to use that one at all?

((Crosstalk))

Sylvia Publ: You don't have to. And it won't hurt that you did it because...

(Jan Mahlman): Oh, okay.

Sylvia Publ: ...you know, we're going to see that you've only reported three all along and not the whole thing.

(Jan Mahlman): Uh-huh.

Sylvia Publ: But what you need to do is go back to the measure specs, make sure you're using the right measure specs for those individual measures you selected.

(Jan Mahlman): Right. You know, those I do have.

Sylvia Publ: Okay.

(Jan Mahlman): We have - I have the three for each one -- all the information in, we're sending them with a penny or getting the N365 back.

Sylvia Publ: Okay. Just make sure that the specifications that you use were from the 2009 PQRI specifications manual and not the measures groups specifications manual.

((Crosstalk))

(Dan Green): We'll analyze these claims for measures to see if you were successful for measures groups because the G code came in that way, but we'll also look to see if you weren't successful that way which obviously you won't be and then whether you were successful with the 80% on three measures.

Having said that, please don't let us stop you from (unintelligible) your providers to a fault.

(Jan Mahlman): We should all take our turn so we can.

((Crosstalk))

(Jan Mahlman): Thank you very much.

Sylvia Publ: That's okay. It's understandable how you might have mixed that up.

(Jan Mahlman): Okay great. Thank you so very much. It's been very helpful.

Sylvia Publ: You're welcome.

Operator: Your next question comes from the line of (Patty Knapp). Your line is open.

(Patti Knauf): Hi. My name is (Patti Knauf). I'm calling from New York, (Robbins) Eye Associates. And I'm quite of confused because I've been listening about all - using just these G codes and we're using Measure 19, which

we have to use a Category 2 code and a G code. I just want to make sure that I have this right that we should use both these together?

Sylvia Publ: If that is the instruction that's on the Measure Specification, then yes, there are - oftentimes there are measures that will tell you to use the CPT Category 2 Code and a G code to report a specific clinical action.

(Patti Knauf): Okay.

Sylvia Publ: And Measure 19 is diabetic retinopathy communication with the physician managing ongoing care.

(Patti Knauf): Right.

Sylvia Publ: And that is the only measure that you are reporting?

(Patti Knauf): No. We're reporting on four, but that's just one that has the G code with that.

Sylvia Publ: Yeah. Yeah, and that's fine. That's the way the measure is specified.

(Patti Knauf): Okay.

Also my other question too for - I'm also doing - we're doing Measure 141, and it comes with two codes and that's the primary open angle primary glaucoma. And then the codes we're using is the 0517F and it says and the 3285F. I just want to make sure that we are to use both those together.

Sylvia Publ: Yes. You would if that's what the instruction says and if that's exactly it, and a lot of the instructions will say, "Two CPT codes or 2 codes are required to report on this measure."

(Patti Knauf): Yeah.

Sylvia Publ: And then right below it'll give you the two codes.

(Patti Knauf): Right, okay. I just want to make sure.

((Crosstalk))

Sylvia Publ: Yes.

(Patti Knauf): Thank you so much.

Sylvia Publ: You're welcome.

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

(Carolyn Roberts): Oh, hi there. I had a question regarding the QDC submission attempts and the errors. Am I correct in my understanding that these don't count against us in the percentage way, so if we report a QDC code that maybe was deleted for a measure for 2009, but we reported successfully on at least three measures, would that actually go into our percentage or not?

Sylvia Publ: The reporting successfully on three measures means that you are eligible for the incentive on that basis. If there was a fourth one and you weren't real successful on it, that would not apply towards the

eligibility at all. Is that what you're asking, maybe I'm misunderstanding your question.

(Carolyn Roberts): In a way, well I have several scenarios but, one, I wanted to know if we report - say, if we report a diagnosis code that's not part of the measure but the CPT code is, and it goes into you with that QDC code, it doesn't count in the denominator, does it?

((Crosstalk))

(Dan Green): It will be ignored.

Sylvia Publ: It would be ignored, right.

(Carolyn Roberts): (Will be) ignored, okay, so that doesn't count against us, okay.

((Crosstalk))

Sylvia Publ: It won't count against you, but it won't count for you either because the diagnosis is wrong.

(Carolyn Roberts): Right, right. So they will just ignore that as just - not a claim that would qualify.

Sylvia Publ: That's correct.

(Carolyn Roberts): Okay perfect. Thank you.

Sylvia Publ: Uh-huh.

(Carolyn Roberts): Bye-bye.

Sylvia Publ: Bye-bye.

Operator: Your next question comes from the line of (Cathy Brown). Your line is open.

(Cathy Brown): This is (Cathy Brown) with Arkansas Digestive Diseases Clinic.

I've had problem with the local carrier. It's not recognizing some of the new PQRI codes for 2009. They're saying they're not valid codes, and they're knocking them out.

Sylvia Publ: Yes. We have become aware that there are some codes that don't have the correct status code and we are taking steps to correct that.

Dr. Rapp will be making an announcement on February 18, National Provider Call, specifically about that particular issue, is there a measure that you were concerned about?

(Cathy Brown): Well there are two of them that they are not taking. It's the 3016F and the 0529F, ones for the followups with colonoscopy and the other is for the - I think unhealthy use of alcohol, and our local carrier does not recognize them.

Sylvia Publ: And your local carrier is...

Woman: Clinical?

(Cathy Brown): Clinical, yes, ma'am.

Sylvia Publ: Yes. The carriers and CMS are working to fix that situation, and you will hear more details about that on the National Provider Call on the 18th.

(Cathy Brown): Okay. And how those affects our qualifying for these measures when we submitted codes will, you know, we submitted clients where the codes didn't make it through.

Sylvia Publ: Yeah. Dr. Rapp is going to be announcing exactly how we'll deal with those.

(Cathy Brown): How you'll deal with it, okay.

((Crosstalk))

Sylvia Publ: Yeah. Yeah.

(Cathy Brown): Okay. All right thank you.

Sylvia Publ: Thank you.

Natalie Highsmith: Okay. (Marshanda), we have time for one final question.

Operator: Okay. Final question comes from the line of Candy Weinper. Your line is open.

Candy Weinper: Hi. Thank you. This is Candy from Southern California and our practice is named Southern California Desert Retina Consultants.

So we have two very quick questions. I understand that you just say that if measures are missing from qualified claims that are submitted

that also is not a good thing. If a patient qualifies for two - more than two or three measures, and we're using four or five in the practice, can we just use one or two measures on their claim or do you prefer that we use all the measures that (unintelligible)?

Sylvia Publ: Why don't you give me the example...

((Crosstalk))

Sylvia Publ: ...for example on a retina case?

Candy Weinper: Yes. We have age-related macular degeneration, so we're using Measure 14, which is the Dilated Macular Exam. We're using Measure 140, which is the counseling on the antioxidant supplement, but they might also be diabetic and qualified for the Dilated Eye Exam on a diabetic patient or the communication of their diabetes to their ongoing treating doctor.

Sylvia Publ: Yes. But the diabetes is not one that you're reporting on, right?

Candy Weinper: Yes, we are.

Sylvia Publ: You're reporting on those as well?

Candy Weinper: Yeah.

Sylvia Publ: And so the diabetes...

((Crosstalk))

Candy Weinper: The ones that - just not the group, just the 117, the Measure 117, Measure 18 and Measure 19.

Sylvia Publ: Right. And so that diagnosis is going on the claim?

Candy Weinper: Yes.

Sylvia Publ: If it's on the claims...

Candy Weinper: We should use all of them, all measures?

Sylvia Publ: Yes, yes.

Candy Weinper: Okay.

Sylvia Publ: And then, just have them point - the pointer should point to the relevant diagnosis for the measure.

Candy Weinper: Okay. But did I not understand that the - if the diagnosis accidentally isn't pointing to it, it's not going to count against us, I mean, we're going to try to have it point to it.

Sylvia Publ: Our analysis will encompass all of the diagnoses that you put on the claims.

Candy Weinper: Right.

Sylvia Publ: So - we'll pick it up anyway.

Candy Weinper: Yeah. But what you're saying is you wanted to point to it if we can.

Sylvia Publ: Well you should point to the correct diagnosis for the measure as much as you can, yes.

Candy Weinper: Okay. Then the second question has to do with Measures 18 and 19, the (community) - (you want me to ask)?

Okay, the communication - well if we do Measure 18, which is the documentation of the presence or absence of macular edema, okay? And the doctor does not do it, for whatever reason he does not perform the dilated exam, 1P, 2P, 3P, 8P, and we also want to use the Communication Measure 19 back to his ongoing doctor.

We're going to attach the 501F, but then which G code - I mean, if it's not performed it, we would put the G8398, if he did perform this measure, we'd use the G8397?

Sylvia Publ: That's correct.

Candy Weinper: Okay. (Are you)...

((Crosstalk))

Sylvia Publ: And don't forget, you've got to use the 5010F as well.

Candy Weinper: Yup, correct.

Sylvia Publ: Yup.

((Crosstalk))

Sylvia Publ: Yeah. You read the specifications correctly.

Candy Weinper: So if we're using on Measure 18, the 2021F with one of the modifiers, 1P, 2P, 3P or 8P, would we also report the G8398?

Sylvia Publ: On Measure 18?

Candy Weinper: If we're doing...

Sylvia Publ: I don't see...

((Crosstalk))

Sylvia Publ: ...code on Measure 18.

Woman: Yeah. (Unintelligible).

Sylvia Publ: I don't see a G code on 18.

((Crosstalk))

Sylvia Publ: No. It's under 19.

Candy Weinper: But if - well I think what you're saying is if we do the 2021F and attach a modifier indicating it was not done...

Sylvia Publ: Uh-huh.

Candy Weinper: ...the only time, we would use the G8398 that it was not performed is if we're also using the 5010F to communicate that information to the treating physician?

Sylvia Publ: Right. Because if he's communicating to the physician, you're going to use 5010F...

Candy Weinper: Yeah.

Sylvia Publ: ...with whatever modifier and G8397.

Candy Weinper: Okay. And if you didn't do it, then the G8398?

Sylvia Publ: Correct.

Candy Weinper: Okay, all right. Thank you very much.

Sylvia Publ: You're welcome.

Natalie Highsmith: Okay, (Marshanda), we have passed our (four-thirty) hour here on the East Coast.

Sylvia, did you have any closing remarks?

Sylvia Publ: Well thank you all for your attention. I'm glad that you - we have such good interest in PQRI and should you have some specific questions I am available for questions. But please use the inquiry mailbox so that we can get back to you. It may not always be me. It may be someone else, but we will try to endeavor to respond to your questions as they come in.

Natalie Highsmith: And that email address again is pqri_inquiry@cms.hhs.gov.

Thank you all again for joining us.

(Marshanda), can you tell us how many people joined us on the phone line?

Operator: Yes. We had 580 lines that were in.

Natalie Highsmith: Okay. Wonderful.

Thank you everyone.

Sylvia Publ: Thank you.

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

END