

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
Special Open Door Forum PQRI: American Gastroenterology Association Institute**

**Conference Leader: Daniel Green, M.D.
Moderator: Natalie Highsmith
September 23, 2008
2:00 pm ET**

Operator: Good afternoon. My name is (Amanda) 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 2008 PQRI Participation by the American Gastroenterological Association Institute 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. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Amanda), and good day to everyone and thank you for joining us for this special open door forum on the 2008 physician's quality reporting initiative with participation by the AGA Institute.

The purpose of this special open door is to help you gain an understanding of the PQRI and encourage participation by providing simple steps that physicians can use to collect and report data to CMS. Successful reporting of this data will make the professional eligible for an incentive payment from CMS.

The agenda has been posted on the special open door forum Web page at www.cms.hhs.gov/opendoorforums with an "s". And on the left hand side you

will see special open door forums, you click on that link and you will see the agenda posted for today's special open door under the download.

And also the PowerPoint presentation has been posted on the PQRI Web page and that link was sent out on the email but if you go to the CMS home page again and do a search for PQRI you will come to the overview page and you can click on the left hand side.

It will say CMS sponsored calls and you scroll down to the related links outside CMS and you will see a link for the September 23 ODF with the AGA Institute and there you can access the PowerPoint presentations for today. An audio file will be posted of this call available beginning September 30 on the special open door forum Web page as well.

I will now turn the call over to Dr. Daniel Green who is the medical officer in the Quality Management and Health Assessment group in the CMS Office of Clinical Standards and Quality.

Dr. Green?

Daniel Green: Thank you, Natalie. I'd like to welcome everybody to today's open door forum. Today's call is being held in collaboration with the American Gastroenterological Association Institute. As Natalie mentioned, my name is Dan Green. I'm a medical officer in the Office of Clinical Standards and Quality and today we're fortunate to have Dr. Joel Brill and Mary Igo on the call as our experts.

Dr. Brill with numerous initials after his name, too many to even mention, is Chief Medical Officer of Predictive Health Limit Liability Corporation which

performs predictive modeling analysis of medical and pharmaceutical claims data and implements proactive patient care management solutions.

His areas of focus include coding and reimbursement methodologies for emerging medical devices and pharmaceuticals, healthcare business strategy, quality improvement and technologies for medical and care management. Dr. Brill is board certified in internal medicine and gastroenterology and has practiced for over two decades in California and Arizona.

He is on the editorial advisory board of several publications, is the AGA rep to the AMA's PCPI and is an assistant clinical professor of medicine at the University of Arizona School of Medicine, an adjunct assistant professor of medicine at Midwestern University and a lecturer at the School of Health Management Policy at the W.P. Carey School of Business at Arizona State University. This is among his many other activities and committees which he serves on.

Mary Igo is a registered nurse and has a Masters in Business Administration and currently serves as the chief executive officer of Minnesota Gastroenterology PA, a position she has held since 1997.

Mary's work experience centers on facilitating cultural and organizational change and she has worked within hospital systems creating service line (care) delivery and development of hospital and physician relationships.

At the Minnesota Gastroenterology Associates she has focused on merging physician practices by establishing a cohesive infrastructure and driving corporate culture design.

So having introduced both of our distinguished speakers I'm going to turn the call over to Dr. Brill to start with the introduction of today's call. Thank you.

Joel Brill: Dan, thank you very much and this is Joel Brill. And as you've mentioned in addition to being the AGA's representative to the AMA PCPI process I'm also the chair of the AGA's Practice Management and Economics Committee. And on behalf of the AGA we'd like to thank CMS for our collaboration in educating members and those who have dialed in this afternoon.

There's several topics that we'll be getting into over the next 90 minutes or so. We'll talk about preparing for participation in 2009, what to expect, what's going to happen with some new pilot measures that may be available in 2009 but we won't know for sure until November.

We'll provide a PQRI update of what's going on now and there will be then time to hear from Mary and from her experience at one of the nation's largest Gastroenterology practices about PQRI and then we'll be able to get into a Q&A period.

One of the things that I think the AGA wants to point out is how we can do well by doing good. There's some simple steps that practices can take in order to collect and report quality data and to earn a Medicare bonus payment.

And so over the coming time, how can we prepare for participation and PQRI program? We'll go over some of the issues relating to measures development that have directly or indirectly impacted gastroenterologists. We'll go over measures, details and specifications.

And I think that there's a basic concept for all of us to remember. One would want to select quality measures that are important to your practice and

patients. It's important to establish processes to systematically report the quality measures for each eligible patient.

We're finding that reporting can mainly be done by either including the quality code on a claim or through registries. It's important for physicians to receive feedback on the extent to which a patient got the recommended care described in the quality measure. At present physicians can receive a modest payment (unintelligible) effort but we can use this process to facilitate practice and patient care improvements.

And so without further ado I'd like to turn this back over to Dr. Green. Dan?

Daniel Green: Thank you, Joel. Just wanted to spend a couple of minutes talking about the background of PQRI and we'll talk a little bit about the 2007 program as well.

The TRHCA, the Tax Relief and Healthcare Act, which was enacted in December of 2006 established the Physician Quality Reporting initiative. PQRI 2007 pays physicians a 1-1/2% bonus for reporting quality measures for the time period July 1 through December 31 of 2007. Providers were asked to select up to 3 measures which were applicable to their practice from a list of 74 measures and they had to report on 80% of the eligible encounters for each measure selected.

They reported against measures on a standard CMS claim form and CMS determined who reported successfully. Then a bonus was paid in mid-2008 so this just went out the end of July, beginning of August, to providers who reported on more than 80% of their eligible patients.

Looking at slide the incentive payment, as I just mentioned, went out in the middle of July. The payments were issued to the tax ID number for all

associated physicians who earned a bonus. So even though the reporting is by the individual NPI, if there were several NPIs in a particular practice the payment was rolled up and reported to the tax ID holder of record. So there could be three or more or there could be several NPIs that were all paid to one individual tax ID number.

The feedback reports were available starting in July and they provided reporting and performance score for each individual so again that was broken down at the NPI level. Also looked at group and national averages for comparison.

So anybody that reported even one quality data code should have had a feedback report that was available to them online. And that would be whether or not the provider actually received the bonus or did not qualify. An individual physician or designated staff person needs to register with a secure system to access the confidential reports. We do have mechanisms to help physicians with registration and the actual receipt of the reports.

Looking on slide number 8 you can see that Congress passed in December 2007 a law which continued PQRI for 2008. This includes many features of the 2007 program. Providers could report codes for individual quality measures and they were asked to report on up to 3 individual measures for at least 80% of eligible encounters. And again the bonus payment for those successfully reporting in 2008 is anticipated as being 1-1/2% of the covered Part B charges for Medicare.

There's some changes and enhancements for 2008. The measure list expanded from 74 to 119 measures. Additionally there are two structural measures; one for electronic health records use and one for e-prescribing using a qualified system. There are also several different reporting options including different

reporting periods as well as using claims, measures groups and registries. There is no cap on the bonus incentive and there was a cap that was applicable to PQRI 2007. That has been removed for 2008.

So talking about, on slide 9, why one might want to participate in PQRI in 2008, first of all it increases your ability to track patients with common conditions through practice management systems.

It promotes a team care and identify team members who are responsible for providing certain aspects of the care and insuring that certain tests and follow up are done for the patient.

You can collect clinical information at the point of care as opposed to a retrospective chart review.

Quality codes which are reported on claims involves minimum burden when the systems are set up in place ahead of time. It's really not that hard to report an additional quality data code on a given claim for a patient with a certain condition. And also the measures can act as reminders for certain care actions.

Looking on side 10, additional reasons to participate in PQRI. You can learn about the ability to routinely provide evidence-based care which is relevant to your patients. Yes, you will receive a modest payment.

You do gain experience in reporting and measuring against quality measures. The programs are likely to continue and even grow for Medicare as well as private payers.

The PQRI experience to inform and be a component of broader quality improvement strategy so hopefully this will be a springboard for providers to implement and enhance their quality improvement within their practice.

Now looking forward to 2009 the MIPPA legislation which was passed in July of 2008 authorizes PQRI in 2009 and it also increases the possible payment incentive from 1-1/2% of covered charges to 2%.

The bonus is still contingent on providers reporting 80% of the time for the eligible patients, for those patients that have a particular disease or diagnosis and also that the provider reports on the three quality measures.

Now again you can report on less than three quality measures if less than three measures apply but you would be subject to a validation process which is actually posted on our Web site.

So looking on slide 12 and speaking of the MIPPA legislation which I was just referring to; again it was passed in July of 2007. It does make PQRI permanent however it only funds the bonus incentive for 2009 and 2010.

As we talked about, it does increase the incentive to 2% and something we've gotten a lot of questions about here at CMS recently, it does add the new e-prescribing incentive for 2009 which would enable eligible professionals to earn an additional 2% if they qualify for the measure and successfully report it. So this would be an additional 2% in addition to the 2% that's authorized for PQRI participation so a total of 4% conceivably.

There are additional provisions for PQRI of 2010 and beyond but I believe that's beyond the scope of today's call.

So having done a little bit of background on PQRI I'm going to turn it over to the subject matter experts to talk about the GI implications. So Joel, I'll turn it back to you. Thank you.

Joel Brill: Dan, thank you very much and I think it's important to preface this by saying the following especially if gastroenterology has been intimately involved in quality metrics and the AGA has made a commitment for several years to put resources into the issue of quality and the like.

I think it's important for those of you who are joining us on the call today to understand that PQRI is not going to go away. Many patients are concerned about the quality of services that they're purchasing and the emphasis on quality of care, reporting on quality of care and public disclosure of your participation rates is really becoming a reality for many of us.

So again we appreciate this opportunity. We think it's important to continue to educate members and broaden participation.

Now looking at slide 13 what are the measures for gastroenterology that are applicable in 2008? There are Hepatitis C measures and those measures were developed based on adoption to the AQA Alliance.

There's, in 2008, one measure on esophageal reflux or GERD medication management. As several of you know, there were four measures in the 2007 measure set but they were not carried over into 2008 as they were not endorsed by the NQF, the National Quality Forum and the results of one measure on BMI screening that appears in the 2008 measure set.

Going a little bit more specifically in slide 14, the 2008 measures include Measure 77 which is a GERD medication management measure. Measures 83

through 90 are the treatment and management of Hepatitis C. Measure 113 is colorectal cancer screening. Measure 124 is health information technology adoption and use of electronic health records. Measure 125 was health information technology adoption in use of e-prescribing. And Measure 128 was BMI screening.

So let's delve a little bit deeper into these measures. On slide 15 you should be looking at GERD Measure 77 and that's the assessment of GERD symptoms in patients receiving chronic medications for GERD. This measure looks at the percentage of patients age 18 years and older with a diagnosis of GERD who have been prescribed continuous PPI or H2 receptor antagonist therapy and who received an annual assessment of the GERD symptoms after 12 months of therapy.

Obviously the intent of the measure is to look and to see do those patients continue to have symptoms that warrant continuous therapy.

On slide 16 we start with the Hepatitis C measure set and starting with Measure 83, that is the testing of patients with chronic Hepatitis C for Hepatitis C Viremia. This measure looks at the percentage of patients age 18 years and older with a diagnosis of Hepatitis C seen for an initial evaluation but had Hepatitis C Viral RNA testing ordered or previously performed.

Measure 84 looks at initial Hepatitis C RNA testing and it looks again for these patients with a diagnosis of chronic Hepatitis C who are receiving antiviral treatments for whom quantitative HCV RNA testing was performed within six months prior to initiation of treatment.

The expert panel developed Measure 85 which was NCV Genotype testing prior to therapy and this looks at the percentage of patients age 18 years and

older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of treatment, as those of you on the call are aware, depending on the genotype, may influence the (LED) duration of therapy.

Measure 86, we're at slide 19 right now, is consideration for antiviral therapy in HCV patients and this measure looks at a percentage of patients age 18 years and older with a diagnosis of chronic Hepatitis C who were considered for pegylated interferon and ribavirin therapy within the 12-month reporting period.

Measure 87, slide 20, is HCV RNA testing at week 12 of therapy and this looks at the percentage of patients age 18 years and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment for whole quantitative HCV RNA testing was performed at 12 weeks from the initiative of antiviral treatment.

Measure 88 looks at Hepatitis A and B vaccination in patients with Hepatitis C. This measure looks at the percentage of patients age 18 years and older who have a diagnosis of Hepatitis C and who were recommended to receive or who have received Hepatitis A vaccination or who are documented immune to Hepatitis A and who were either recommended to received or have received Hepatitis B vaccination or who have documented immunity to Hepatitis B.

As we said at the beginning, doing well by doing good.

Slide 22, Measure 89, looks at the counseling of patient with Hepatitis C virus regarding the use of alcohol. Now this looks at the percentage of patients age 18 years and older with a diagnosis of Hepatitis C who received education

regarding the risk of alcohol consumption at least once within the 12-month reporting period.

Measure 90 on slide 23, the counseling of patients regarding the use of contraception prior to starting antiviral therapy. This looks at the percentage of female patients age 18 to 44 and all men age 18 and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatments who were counseled regarding contraception prior to the initiation of treatment.

This goes through the Hepatitis C measures and we'll then go next turn our attention to Measure 113, colorectal cancer screening. This is a measure which looks at the percentage of patients age 50 through 80 years who received the appropriate colorectal cancer screening.

Now while we're not going to go into this measure in great detail at this time we will point out that the appropriate colorectal cancer measures are those that currently have been defined by Congress to Medicare as being appropriate for the colorectal cancer screening benefit. This measure unfortunately cannot be accomplished by the patient being referred to a gastroenterologist who then performs the screening colonoscopy.

Let's move to slide 25, ERH adoption, Measure 124. This looks at the adoption and use of health information technology and electronic health records. It has become apparent that there is a need for gastroenterologists and other physician specialties to adopt electronic health records in order to keep track of their electronic information in order to improve patient care.

This measure documents whether the provider has adopted and is using health information technology. To qualify the provider must have adopted a qualified electronic medical record, is either certified by the CCHIT or is capable of all

of the following; generating a medication list, generating a problem list and entering laboratory tests as discrete searchable data elements.

This also takes us to Measure 125, e-prescribing. This is a measure that documents whether the provider has adopted a qualified e-prescribing system and the extent of use in the ambulatory setting. To qualify, systems must be capable of all of the following.

They must be capable of generating a complete active medication list, selecting medications, printing prescriptions, electronically transmitting prescriptions and conducting all safety checks. Providing information related to the availability of lower-cost therapeutically appropriate available alternatives, if any, and providing information on formulary or tiered formulary medication, patient eligibility and authorization requirements from the patient's drug plan.

And, Dan, if I'm not mistaken this measure will be affected by the implications of the MIPPA legislation, correct?

Daniel Green: That is correct, Joel. This measure is the measure that is alluded to in the MIPPA legislation and for 2009 will be removed from the PQRI program and will be the e-prescribing measure that again is described in that legislation.

Joel Brill: Great. Thanks.

Daniel Green: Thank you.

Joel Brill: Let's move forward now to slide 27 which looks at BMI screening, Measure 128. This is a measure that looks at universal weight screening and follow up and the measure looks at the percentage of patients age 65 years and older

with a calculated Body Mass Index or BMI within the past 6 months or during current visit that is documented in the medical record and if the most recent BMI is great than or equal to 30 or less than 22, a follow up plan is documented.

I know that many gastroenterologists sometimes forget that our focus is not just the hollow tubology but really that our focus is on digestive disorders. And I would encourage those of you who are participating in the call and those who are not, to remember that BMI screening and looking at the greater issue of weight is very important for gastroenterologists to be looking at for their Medicare beneficiary and other patients.

Well, this takes us to slide 28 and what are some of the proposed 2009 PQRI measures that are applicable to gastroenterology? In Hepatitis C there's a proposal of modification which has been based on NQF endorsement.

The GERD medication management measure still appears in the proposed rule measure set and there's also one measure in BMI screening in 2009 in that proposed measure set.

I think most importantly from the standpoint of gastroenterology and others who perform Endoscopy is that there is a new measure proposed in 2009 and that is the first Endoscopy that measure. This measure is entitled Surveillance Colonoscopy Interval for Patients With a History of Colonic Polyps and Avoidance of Inappropriate Use.

This measure was developed via the PCPI process in a process where all three GI societies as well as other interested parties came together in a PCPI during 2007 and 2008. It was recently adopted by the AQA Alliance and in the

proposed rule released CMS earlier this summer this measure appeared in the measure set.

Let's talk a little bit more about the potential changes and let's go over these in a little bit greater detail. Slide 29 talks about the Hepatitis C measure and notes that Hepatitis A and B vaccinations have been proposed as two separate measures although I'll point out that the NQF endorse those as paired measures.

So Measure 84, Hepatitis C RNA testing before initiating treatment and Measure 85, HCV genotype testing prior to treatment, have been NQF endorsed as paired measures. Obviously we'll be waiting to see in the final rule what the agency elects to do.

As Dr. Green has mentioned, the HIT adoption measure has been eliminated as the e-prescribing requirements are implemented and with the Endoscopy Polyp Surveillance Measure we will be waiting and watching for measure specification. In fact there are some things coming up including the upcoming AMA's PCPI meeting which will be taking place on Wednesday through Friday of this week as well as an AQA Alliance measure meeting in mid-October and October 24 that will also be addressing this measure.

Let's go to slide 30 if we might and let's look at the Endoscopy and Polyp Surveillance Measure. This measure looks at the percentage of patients age 18 years and older who are receiving a surveillance colonoscopy with a history of a prior colonic polyp in previous colonoscopy findings, who had a follow up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report.

And as we've mentioned, the measure specifications will be released in the near future by the AMA and will be posted on their Web site and it should also be posted on the Web sites of the Gastroenterology Society's as well.

This is important. This is good. It's good from patient care and it's also very, very good for gastroenterology because unlike some of the other measures, which may have affected a subset of our gastroenterology community, I think many of us on the call would agree that this measure directly speaks to a service that many of us provide not only to Medicare beneficiaries but to all of our patient set.

Now looking at slide 31 we'll note that the physician fee schedule's proposed rule that was released earlier this summer does include the measures proposed for the 2009 PQRI and we anticipate that the measures will be published when the final physician fee schedule is released in November.

So what are some of the reporting options? The agency has proposed alternate reporting periods and criteria which can significantly increase participation and reporting options. There is a January 1 through December 31 reporting option and now a July 1 through December 31 or a 6-month reporting option. There are also a total of nine PQRI reporting methods, three which are claims-based and six are registry-based.

For the reporting period of January 1 through December 31 Option 1 would be to report individual quality measures and reporting on 3 quality measures for 80% of your eligible patients.

Should a practice elect to use reporting period of July 1 through December 31, 2008, there are options. Option 2 allows the group to report a measure group

for 15 consecutive eligible patients and Option 3 allows reporting a measure group for 80% of the eligible patients over that six-month period of time.

Let's go to slide 34 which looks as reporting individual quality measures. If you have reported on three individual quality measures through claims for the first of 2008 your practice should continue to do so. If you also reported in 2007 then you should use the CMS reporting and performance feedback from that year to assess whether to adjust your 2008 participation. And on the AMA Web site there's a measure-specific PQRI data collection worksheet that is available.

As Dr. Green has mentioned, the bonus payment for full-year successful reporting for 2008 would be 1.5% of the Medicare allowed charges over the 12-month reporting period. But it's important to remember that it's not too late to start reporting individual quality measures and hit that 80% threshold of eligible cases.

As we're going to hear from Mary in a few moments time, it requires a systematic way to identify those patients when they come into the office. It's important for your practice to assess whether patients eligible for selective measures have been seen in the office for the first six months of the year or are likely to be seen in the second half of the year. And as been mentioned, the agency has offered this new reporting option which may allow you to report a measure group or 15 consecutive patients such as for preventive care.

Let's go to slide 36 which looks at the measure group reporting. A measure group is a group of individual measures covering patients with a particular condition or preventive services. Here you would report the applicable measures in a measure group for 15 consecutive eligible Medicare

beneficiaries or you would report applicable measures in a measure group for 80% of eligible beneficiaries during that six-month reporting period.

That means that you can earn the bonus even if you failed to report on 15 consecutive beneficiaries. I think we're pleased that the agency has done this because it provides a potentially more straightforward reporting method.

Again the bonus payment for a successful reporting in 2008 is 1-1/2% of the Medicare allowed charges over that six-month reporting period. Unfortunately there's no measure group that is specifically geared to gastroenterology but gastroenterologists can report to preventative care measure group.

Now the agency has also proposed registry-based option. Now if you go to slide 37 you will see that CMS will now accept quality information reported from a clinical registry on behalf of physicians. Registries collect physician-submitted data. It's typically related to a clinical condition or specialty. General registries are also available and for that we would point invited listeners to see the CMS Web site for further details.

Registry data can be used in a number of ways to earn a PQRI bonus payment. For example registry data for up to three individual measures for 80% of eligible encounters over the 30 or 15 consecutive patients or 80% of measure group eligible cases. The nature and the duration of reporting determines if a bonus payment is equal to the allowed charges for the 12 or 6-month period of time. While there are no gastroenterology-specific registries at this time there are registries that are collecting gastroenterology related PQRI measure data.

So if you decide to submit quality data to a registry it's important to do it at the CMS Web site at www.cms.hhs.gov/PQRI and click the reporting tab for an updated list of the qualified registries.

You then want to contact the registry to see if they will report the measures that you want to report and for the reporting period that you want to report. And I think it's important for you to express your interest in having your data submitted for the purposes of participating in the PQRI program.

Well, at this point what I'd like to do is I'd like to turn this over to Mary Igo. As you've heard from the introduction Mary is the CEO of Minnesota Gastroenterology and that practice has had extensive experience in participating in quality measures development, reporting and the PQRI program.

So, Mary, perhaps you could take it from here and tell us the real nitty-gritty of how to really participate and submit claims.

Mary Igo: Thanks, Joel, the down and dirty. When you're involved in submitting the claims it really - and I want to go back to a comment that Dr. Green made - having everyone know their role and what they're supposed to do is critical. If everyone isn't on the same page it has, you'll get the first year's data the way we did.

You can submit claims electronically or on paper for PQRI. The paper portion, my understanding is region-specific or code-specific so you may want to check in your area what your paper claim options are.

You need to put your NPI number in the rendering physician field on the claim, quality data code lines need to be put on a separate line and that G-Code would have a charge of 0 or .01. The reason the 1 cent is some systems won't accept sending out a 0 claim and they'll avoid printing that line so check with your EPM provider.

The steps in the reporting process really are defining what measures and measures you're going to do, again assigning roles and responsibility for people, putting the systems in place using a coding tool and a worksheet and this is a portion that the physician has to be involved in so that has been a key communication point on our part to make sure everyone is up to date on what they should do. And I'll tell you some of the pitfalls when we get into our 2007 experience.

Attach the copy of the coding tool or the worksheet to the super-bill so that the coder can enter the right G-code and the coder would verify patient eligibility, pertinent encounter and correct quality codes. And this eliminates the physicians' need to identify which insurance, which patient, all of that sort of thing; avoid some time lag on your part or time use.

Steps in the reporting process which is slide 41, put the NPI for each physician on the claim, keep a log of the information that you've been sending out, look at your own data to improve. Use the experience to establish and refine systems and look for other opportunities. The bonus payments and the PQRI concept is going to be coming in various parts of the market. And then it really is I think the whole basis is developing a culture for quality within the practice.

Minnesota GI's PQRI experience was really based, as Joel said, on the fact that we've had a lot of quality influence and about four years ago put emphasis on developing a culture of quality, a safe and respectful environment.

We have 56 physicians, 21 NP/PAs and in 2006 was the first year that we really put quality measures out there for compensation. There were two

measures, a clinical measure and a business measure, and the ranges of the compensation that was given to the physicians 30% to 100% of the whole. And interestingly enough some of the people that got 30% were some of the physicians' leaders. I think they forgot to practice what they were preaching.

In 2007 we implemented PQRI with a little force. The IS Department here and again we are a large practice but we have little pods with sort of a central service philosophy. IS is centralized and the measures had been identified that we could possibly report on.

It looked like it was going to be very cumbersome by looking at the information on the CMS Web site and some of the things that we knew with the EMR and we do have an EMR in place. At the time in 2006 when we looked at this, we were only doing the endoscopic reports on the EMR and bringing in transcription documents that the doctors would dictate.

We sat down with communication, with the IS people, with the doctors, really looked at what this was going to entail. Our IS Department said no, too much work and I think after a little bit of pressure on the fact that this was not just a one-time thing that we were doing, this was really going to be a wave of the future, we finally got everybody in agreement to give it a try.

But we did a lot of email communication. We have a fair process methodology in the practice so that it's presented, it goes off to small team meeting or the small group meetings and they discuss it, get the feedback back. We again process it through and try to come up with a solution that everybody understands why we're doing what we're doing.

We did a pop-up screen with questions and the questions were not mandatory. The doctors could choose. When the charge ticket came up they could choose

to bypass that if the patient wasn't applicable. Because it came up 100% of the time everybody quickly got used to dismissing it as not applicable.

So if you look at the 2007 measures that we did on the GERD measures, and I believe that's slide 44, we had lots of encounters on GERD and that would fit into the category of 60, 61 and 62. In 60 we had less than 4.3% compliance, 61 - 61.6% and 62 again 4.3% compliance on the physicians' part and it had to really do with the fact that they dismissed it. It was not mandatory.

In 2008 again committed to the fact that we're going to continue to work towards perfecting this internally we made these mandatory fields but the mandatory fields really related around the codes. So if a patient had this code and that code the pop-up would come up and the doctor would complete it.

The coder would verify that it was or was not applicable to this particular patient just as a safety check and you'll see that we have basically 100% compliance. The 98.8%, the 91.7%; the reason that that's there is really timing-wise between when the patient was seen and when the charge ticket was actually processed.

In slide 46 I have attached the screenshot of the mandatory pay per performance quality measure number 77. This is what the physician would see pop up and this is something that could be printed off and attached to the charge ticket so the doctor could determine at any given time whether this applied or not if you're on a paper system rather than EMR system.

And the next slide is the mandatory pay per performance for number 88, Hepatitis A and B vaccine in patients with Hepatitis C. And again the documentation is automatically done by the physician at the time that he's doing the charge ticket. It is processed. The charge ticket part is processed

through the EPM, something that almost everybody has, and the actual template itself is in the EMR which coordinates the data back.

Now we're very proficient on pulling data and can use these templates to be able to pull our own data to look at how did we do and how are the doctors doing. Because we're also doing this in a lot of other quality measures which we're looking at more for value statements than just cost issues, the doctors are very accustomed to looking at these type templates and again have been brought into the process to identify what's the easiest way, what can they live with and what needs to be mandatory in order to get the job done.

I think everyone here is really committed to the fact that this is a wave of the future. We have seen it with two of our payers in the marketplace here in Minnesota and we'll continue to evolve this as it ties into the quality measures that we're doing within the practice to insure safe and valuable care.

And with that I will turn it back to Dr. Green.

Daniel Green: Thank you very much, Mary. We appreciate the personal insights into how you work with your group to make PQRI successful for the folks in the Minnesota group. Joel, also thank you very much for the insightful comments you added to today's presentation.

Fortunately we have a fair amount of time for some questions so I think we will turn it back to (Amanda) and we can start the question session, question and answer session if everybody's in agreement with that.

Natalie Highsmith: (Amanda), if you can just remind everyone on how to get into the 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: And at this time as a reminder if you'd like to ask a question please press star and then 1 on your telephone keypad.

The first question is from (Carol Romano) from New York. Your line is now open.

(Carol Romano): Hi, my name's (Carol Romano). I'm from Colon and Rectal Surgeons of (Unintelligible) in Long Island and this question is for Mr. Green. We're a sub-specialty group and we are a member of AGA but many of the quality reporting initiatives that are applicable to gastroenterology are not applicable to colon and rectal surgery.

So where do I go to try to find three codes that we can use? I mean I've been on the CMS Web site. It doesn't make it easy to find the G-codes. I found some codes that can be used in a surgical situation. Unfortunately the Endoscopy code as it exists now isn't that valuable to us since most of our patients are referred by another physician so the new Endoscopy code will be useful but that is not in existence yet but in the meantime I have to find three measures that we can report on. So can you give me some guidance about that?

Daniel Green: Sure. You know, great question. We make every effort to make our Web site as thorough and complete as possible and sometimes in the effort to do that the amount of material we have on the Web site becomes voluminous to say the least.

(Carol Romano): Yeah.

Daniel Green: Toward that end we've tried to come up with, we started with the PQRI Made Simple, reporting the measures groups. Now this would not be applicable probably to the general surgeons, our colorectal surgeons, but it is intended for folks that do a little bit more primary care. It may be pertinent to some of the listeners on the line. It's about a three-page sheet, that's including like a full page table. So instead of reading the pages and pages and pages of this is how I do it, you can refer to that particular document.

In your specific instance however you might consider looking at the peri-operative care measures, which as I recall, are measures 20, 21, 22 and 23. I'm not sure whether 20 is included in there; I believe that it is.

And there are codes in those measures again if I'm recalling correctly that would be appropriate for certain types of colorectal surgery procedures. Have to do with antibiotic administration and discontinuation as well as venous thromboembolic prophylaxis. So those would be measures certainly that surgeons could report on.

Additionally there are many measures in PQRI which are general. So they don't really refer to - now any of the measures can be reported by any type of practitioner if they feel that they're relevant to their practice but if you're using an electronic health record or e-prescribing, certainly those would be measures but really they're not specialty-specific.

Additionally other measures include the (Fall) measures, the medication reconciliation. These are general measures that any practitioner really can report on.

(Carol Romano): And how do I get to the G-codes? Like for instance I have some of the G-codes that I can use regarding the antibiotic prophylaxis but when I go to CMS and I printed out reams of paper this week getting ready for this meeting, I see areas, you know, measures specified but not the G-codes that go with the measures.

Daniel Green: Okay, so if you go on our Web site as I believe you have, that cms.hhs.gov/PQRI...

(Carol Romano): And I'm there.

Daniel Green: ...if you see on the left side of that Web page there's a tab that says measures/codes?

(Carol Romano): Okay.

Daniel Green: Yes, so if you click on that you'll go over to the download section and the measure specifications for 2008 are listed there. It's about a 343-page pdf/. You don't need to print all that out but then if you scroll through and look for the different measures, the (Falls) measure I was discussing is measure number 4. There's peri-operative care as I mentioned were Measures 20 through 23. There's a medication reconciliation which I believe I Measure 46 or 47.

In any case if you read through each measure, roughly about two or three pages, some times four pages when you include the science behind the measure, and in there will be CPT2 codes. Not all measures have G-codes; some of them have CPT2 codes which are quality data codes that the AMA has developed to express a particular quality action associated with a measure.

So, you know, you may be looking specifically for G-codes and some of the measures you're looking at may actually have CPT2 codes instead of G-codes. Those will be like a four-digit number typically with an F on the back of it so like 1016F and then you can sometimes attach a modifier to that like a 1P, 2P, 3P or 8P modifier depending on the particular measure.

And those modifiers tend to have to do with whether a quality action was not done for a particular reason/ either a medical reason like you didn't give antibiotics because the patient was allergic, a patient reason, the patient refused to get the test or the blood that was recommended or refused the antibiotic or medication, whatever it was or a system reason and there's an 8P modifier that says I didn't do it and I didn't provide any particular reason why I didn't do the quality action.

(Carol Romano): I guess I'm going to have to keep looking through that bar because I've been there and I can't find that 300-page document you're referring to.

Mary Igo: If you - and I'm not - am I open to the call?

(Carol Romano): Sure.

Mary Igo: Okay. On the AMA Web site and I'm sure, I'm hoping I'm not talking out of school but there is a professional resource, (Carol), as a quality measure. It's for 2008 PQRI. They have the measure listed and then to the right they have the measure description, the data collection sheet and the coding specifications and they're all very neatly laid out.

(Carol Romano): Thank you so much. I'll look for that. Thank you, folks.

Operator: Thank you. The next question is from (Barbara St. Juliano) from New Jersey.
Your line is now open.

(Barbara St. Juliano): Yes, hi, This is (Barbara St. Juliano) from the Robert Wood Johnson University Medical Group. I have a question for Mary. I'm sorry, Mary, you're going to be popular today. It's about your mandatory PQRI reporting in 2008. Does your EMR actually prevent the doctors from leaving the chart until they've made an entry?

Mary Igo: Yes.

(Barbara St. Juliano): Or have you had to bounce some of that to your front desk, they have to be the final verifiers?

Mary Igo: No. The doctors cannot leave that screen until they've made an entry.

(Barbara St. Juliano): That's a great system. We're not using that same electronic medical record I guess because we're unable to do that type of intervention.

((Crosstalk))

Mary Igo: I would check with your...

(Barbara St. Juliano): ...go that route?

Mary Igo: Check with your vendor and see. The only other thing would be to do, what's worked very effectively here is to put up the statistics of the people that have been compliant and we don't put, we (don't) identify who they are but they know who they are and if they fit on the far end of the bell curve they quickly move towards the middle.

(Barbara St. Juliano): And if I could just ask one more question, then I'll excuse myself. It's in reference to the 2007 reports. Have you been able to access them on the IACS site or did someone in your organization do that?

Mary Igo: I have not looked at them yet but I understand that someone in the organization did and the person that did is the same person that does the credentialing for CMS. She does all the credentialing for all the payers.

So what I heard was very cumbersome to get into, worked rather easily for her because she's in tune with what the questions are and what the definitions of what they're looking for.

(Barbara St. Juliano): All right. What we did is we did our own internal tracking as you indicated you did for QI and when we tried to validate it against the CMS reports in IACS we couldn't get them to work out.

Mary Igo: To match?

(Barbara St. Juliano): Right.

Mary Igo: I haven't looked at that but that's interesting. I will ask for that information.

(Barbara St. Juliano): Yeah. And it could just be that we don't, we're counting our cases incorrectly. We wanted to validate the two to see if we were even close. I hate to give my doctors an estimate of whether or not they're on target for the reporting 80% if they're really not and to tell them they're not when they are.

Mary Igo: M-hmm.

(Barbara St. Juliano): But I just, you know, that's a good heads up.

Mary Igo: I think some of them, maybe it's timing with things that were disallowed and kicked back for some reason.

(Barbara St. Juliano): It's possible.

Daniel Green: (Barbara), not to open the flood gates but be easy on me, everybody on the call, but we are looking into some folks that had reported discrepancies not on a case by case basis but generally in terms of trying to learn from, you know, from our 2007 initiative. And we have discovered some common I won't say problems but some common circumstances if you will.

Mary Igo: Opportunities.

Daniel Green: There you go. And once we've finished identifying these we will be coming out with, you know, to educate the public and the providers that participated about, you know, where they may not have been successful.

Some of it has to do with whether providers actually submitted an NPI with both their quality data codes as well as their claims because as I understand it for the claims at least, the NPI was not absolutely mandatory for the entire part of 2007.

Mary Igo: You're right.

Daniel Green: So you can imagine that if the NPI didn't come in with the claim, you know, when the practice calculates what they feel their incentive payment should be there could be a discrepancy. That's one of the common things we found that I can tell you about at this point. The rest of it's still kind of ongoing so I really

don't want to be, until we have all the information I don't want to be premature.

(Barbara St. Juliano): Sure. Well, thank you. That's good feedback.

Daniel Green: Thank you.

Operator: Thank you. The next question is from Kevin Craig from Massachusetts. Your line is now open.

Kevin Craig: Hi. Kevin Craig. I'm from a management services organization, multi-specialty. We've got about a dozen gastroenterologists. And someone said that it's not too late to start reporting the codes now for GI and still be able to hit the 80% reporting requirement by the end of 2008 and I just wonder how realistic that is or whether we're really working towards 2009.

If you still think it's possible to hit the 80% reporting by starting let's say even next week for 2008 can you give me some more specific information on which codes could be used to hit the 80% mark given that we've, you know, only got three more months left?

Daniel Green: Joel, do you want to do that or do you want me to take that one?

Joel Brill: I think if you take that one, Dan, that'd be great.

Daniel Green: Okay. So the reason why we suggest that to providers, there are some measures, there's at least 60 measures and a list of those 60 measures is in fact on our PQRI Web site, that require a practitioner to only report them one time per patient per year.

So you can imagine, and again not that this is necessarily specific to GI but you can imagine that if it's for the diabetes measure for instance, I'll just use that as an example, if the hemoglobin A-1-C only needs to be reported one time per year and you see half your diabetic patients in the first half of the year, then you see them again the second half to find about how their sugar is doing, even if you reported them in the second half of the year you could easily achieve 80% or more again provided those patients are seen twice during the year.

So again the measures that only need to be reported one time, you could conceivably be successful. The things like the electronic health record measure; that's intended to be reported on every single claim so obviously you're absolutely correct. You could not achieve 80%, you know, starting in September unless you were a new practitioner who started with the group in let's say in August.

Additionally however you could have your providers report the preventive care services on 15 consecutive patients. And if they look on our Web site at the PQRI Made Simple document, again that's a really easy to follow document. It was well written by some genius here at CMS - that would be me, just kidding - who wanted to try to water down the paperwork for providers.

So I know that gastroenterologists don't necessarily always do primary care but I'm sure that they also do things like checking on, you know, inquiring whether their patients smoke, perhaps recommending that they have their influenza shot and things like that that are general in nature because they all have internal medicine training as well.

And again it's only 15 consecutive patients which would qualify them for the six-month reporting period and they wouldn't get a 1-1/2% of the 12 months but they would get 1-1/2% of the six months.

Kevin Craig: Yeah, just a follow up. Could you get somebody there who is a gastroenterologist or involved in gastroenterology to tell me which of the 60 measures are one per year that would apply to GI?

Daniel Green: Yeah, I'm sorry, I don't have that - we're not in a place where I'm at a computer where I can pull that form up but the form is on the Web site with the 60 measures and it has just the titles there. So you could actually just read the titles and be tuned in to which of the 60 would be applicable.

If you want to give me your email I will try to locate that for you and send it out to you.

Kevin Craig: Great; kevinwraig -- C-R-A-I-G -- @comcast.net.

Daniel Green: Okay, I'll get it to you in the next day or two.

Kevin Craig: Thank you very much.

Daniel Green: Okay.

Operator: Thank you. The next question is from (Peter Donaldson) from North Carolina. Your line is now open.

(Peter Donaldson): Yeah, this is (Pete Donaldson) from Digestive Health Specialists in Winston-Salem, North Carolina. I guess a follow up question to Dr. Green. We did participate in 2007. Unfortunately struggled with that participation

and in going back, did not receive any payment in 2008. When we went back and audited what we sent in versus what Medicare had on the quality reports the data was nowhere near close to being the same.

And it's kind of frustrating that, you know, to hear that we're kind of in a trial testing period when they're assigning dollars to it. Is there any sense of going back and auditing that numbers and reissuing checks and reimbursement for what appears to be incorrect data on CMS' part?

Daniel Green: Great question. Certainly the TRSHA statute does not provide for an audit process however as I did mention, we are looking into it and I hope that my earlier comments won't be misinterpreted. I was not trying to suggest that the error in submission was necessarily on the - or transmission - was necessarily on the part of CMS.

We found that many practices unfortunately did not have their NPI number on the claim when it was sent in and then we also found where the NPI was actually on the claim that was sent by the, you know, that was originated in the doctor's office if you will but when they sent it through their intermediary before it got to the carrier, so some of these electronic systems have intermediaries.

The NPI was stripped off in some instances during that step which would be before CMS would ever have an opportunity to receive the claim. So again I'm not saying that those are the only problems by any stretch of the imagination. But those are things that we've been able to identify at this point.

So we want to look at the situation globally, try to get an idea or at least an estimate of how many providers may have been affected and obviously one thing we want to do is, you know, try to make sure that these things don't

happen again in the future. But, you know, more than that we're trying to get all the information and evaluate it.

So I appreciate your comments and certainly I would be frustrated too but I don't want to mislead you into thinking that somehow the data was necessarily messed up here at CMS.

(Peter Donaldson): Well, I guess the data's messed up if there's not an appropriate, you know, process for sending the data in. NPIs weren't required for claim forms. Were NPIs required for PQRI and was that in the descriptions for PQRI?

Daniel Green: Yes, NPIs were required for PQRI so again...

(Peter Donaldson): I don't even think they were issuing NPIs when the PQRI legislation came out.

Daniel Green: In fact they were actually but putting that aside you are correct in that NPIs were not absolutely mandatory at least in the early part of 2007 for claims but they were mandatory for us to be able to match up to try to calculate the incentive payment. So it is, as part of PQRI it was necessary to submit the NPI.

And as I mentioned, some of the programs that folks use in their offices for electronic billing, when it went from there to whomever they send it to, I think they send it to some sort of intermediary or warehouse, clearinghouse, I'm sorry, we found that there have been instances where the NPI has been stripped off there which is again before we ever receive it.

Now again I'm not saying that, we're looking into this so we don't have all the answers by any stretch of the imagination at this point nor do we have

proposed solutions. But we are looking into it and we're doing our best to try to figure it out because we can appreciate the frustration that the providers and the community are feeling.

(Peter Donaldson): Well, just it seems like it was a hastily put together program and then, you know, dollars are tied to it. You know, it just doesn't seem to be, you know, a fair program if all the kinks aren't worked out and yet we're tying dollars to it.

I guess that's my other question is the 1-1/2% and 2-1/2% and there's a lot of confusion over what that 1-1/2% is. You know, the average check to physicians was \$700 yet, you know, the average physician didn't receive \$7000 in Medicare payments.

So is the 1-1/2% of the global billings to Medicare or is it just for those codes? There's still a lot of confusion around what that incentive payment, I mean everybody looks at that as being 1-1/2% or 2% of your total Medicare billings when it didn't really work out to be that way.

Daniel Green: And I think that gets back to what your original statement about the NPI necessarily being attached to the claims but it is 1-1/2% of your covered Part B charges. And again for 2007 you have to remember, that would only be for the period July 1 through December 31.

And, you know, another way to look at it, it's not just on the patients for whom you submit the quality data. It's not just those charges. We did some looking to see how many claims folks were submitting.

Actually it was the American Academy of Family Practice I believe or the American College of Physicians, forgive me I don't recall which of those organizations, but they looked at the average number of Medicare folks that

were being submitted on for three measures and they found it to be, I want to say in the 30s, 40s, again I'm not 100% sure of the number but somewhere in that neighborhood.

And when they did the math they found that for those patients they found that they were receiving on average roughly another \$30 or \$40 per claim just for reporting those quality data codes. And in their determination they thought that that was a very worthwhile effort or amount rather for the effort that was expended in terms of adding the codes.

So again it is 1-1/2% for 20007 of that six-month reporting period. It's 1-1/2% of whichever reporting period the provider uses for 2008 be it 6 months or 12 months and in 2009 it goes up to 2% of the covered Medicare Part B charges.

Joel Brill: Dan?

Daniel Green: Yes.

Joel Brill: Hi, this is Joel again. I wanted to follow up on the previous question of, some people have asked this question of how do I find the simple measure sets especially if they couldn't find any GI-specific measures and I'd like to point the listeners to a simple way of finding those measures if I might.

Daniel Green: Thank you, Joel. We would appreciate that. Thank you.

Joel Brill: Sure. You know, if those on the call go to, you know, the Web site www.cms.hhs.gov/PQRI there is a panel on the left which has a number of hyperlinks and one of those hyperlinks on the left side says PQRI toolkit. And if you click on that it takes you to a site which is entitled 2008 PQRI Toolkit: Steps for Success.

At the bottom of that there's a download and the download is called 2008 PQRI Claims-Based Measure Group Handbook. If you click on that link it takes you to a document which initially appears a little bit daunting because it's 41 pages but if you just click to the third page, the third page actually shows you the measure set for the preventive care measures group.

And in that measure group as you've mentioned, some of the things would include screening for osteoporosis in women aged 65 or older, influenza vaccine for patients greater and equal to 50, pneumonia vaccine for patients 65 and older. As mentioned, screen and mammography, colorectal cancer screening, inquiry regarding tobacco use, advising smokers to quit and one of the other measures we've already mentioned, universal weight screening and follow up. So they're all listed in that document.

(Peter Donaldson): Thank you, Joel.

Daniel Green: Thank you.

Operator: Thank you. The next question is from Brandy (Yingley) from South Carolina. Your line is now open.

Brandy (Yingley): Hi, this is Brandy (Yingley) calling from Coastal Gastroenterology in Hilton Head, South Carolina. I'm not sure who to direct this to. I have a couple of questions on colorectal screening reporting. We're a little confused on when it is appropriate to report for the PQRI on these patients that are coming in for routine screening.

And when a patient comes in for their first time and they're coming in because they are 50 and it's time for them to have a colonoscopy but they don't have

any other issues, it's my understanding that that's under Medicare actually so they would be 65. It's my understanding that they would not be eligible to be in the PQRI reporting measure, is that correct? Am I making sense?

Joel Brill: You are making sense,

Brandy (Yingley): Okay.

Joel Brill: And this is Joel and I'll take that one and actually you're referring to Measure 113.

Brandy (Yingley): Right.

Joel Brill: Which is the colorectal cancer screening.

Brandy (Yingley): Right.

Joel Brill: And I believe also in the call is (Debbie Robin) who is the director for the AGA Center for Quality. And I know (Debbie)'s had a number of discussions with both CMS and CQA who's the owner of this measure.

(Debbie), if you're on the call would you be able to speak a little bit further about the interpretation of this measure?

(Debbie Robin): Sure. Thanks, Joel, and thank you for the question. Basically the measure was developed as a measure by NCQA to assure that folks were getting their screening and the documentation of the same. So to that extent only when the patient does in fact have the screening does that count if you will towards the measure.

Brandy (Yingley): Okay.

(Debbie Robin): But the way it's coded, the coding requires an office visit, not the procedure visit.

Brandy (Yingley): Right, that's a little confusing. Right.

(Debbie Robin): Yeah, so they would have to come back for - if they were coming back for a follow up of some type then you could document it. If it's a patient that you're seeing on an ongoing basis and, you know, you saw them, visit one, knew they needed to be screened, did the screening and then they came back for a second office visit after the screening...

Brandy (Yingley): Right, for another issue.

(Debbie Robin): Right. And that time the provider would look back, say yes they were in fact screened and then you could count that. But it is not coded for you to actually document at the time of the procedure if the colonoscopy is the particular screening method that you're using.

Brandy (Yingley): Right. I also have another question. When a patient has, you know, they come in and they say I had a colonoscopy eight years ago with Dr. So-and-So. I've moved here and I don't have any records and these records aren't, you know, we're not able to get the records for whatever reason. I mean do you have to have that supporting document? Does it just need to be noted in there, document in their chart that they say that they had a colonoscopy or do you actually need to have the actual medical records from the previous one?

Is that making sense?

(Debbie Robin): Yeah and I apologize. I don't have the coding right in front of me but I'll be happy to follow up with you offline unless someone from CMS happens to have that readily available.

Daniel Green: I'm sorry. In my haste to get down here on time for the call I did not bring my measures code book with me. I apologize.

(Debbie Robin): Okay. May I get your contact information?

Brandy (Yingley): Sure. My email is brandyy@coastalgastro.com.

(Debbie Robin): Okay, great. I will follow up with you.

Brandy (Yingley): Thank you very much.

(Debbie Robin): Sure, thank you.

Brandy (Yingley): M-hmm.

Operator: Thank you. The next question is from (Maria Meza) from Washington. Your line is now open.

(Maria), your line is now open.

Natalie Highsmith: Hi, (Maria)?

Operator: (Maria), your phone might be on mute. Your line is now open.

Natalie Highsmith: Okay, let's move to the next question, please.

Operator: Okay, that's fine. The next question is from (Michael Flynn) from Missouri.
Your line is now open.

(Michael Flynn) from Missouri, your line is now open.

(Mary): Hi, this is (Mary) from Dr. (Michael Flynn)'s office in St. Louis, Missouri.
Can you hear me?

Natalie Highsmith: Yes, we can.

(Mary): All right. My question is, when you have a multi-specialty group like we do,
do all physicians under the same tax ID need to participate in the PQRI or can
individual physicians participate?

Daniel Green: Individual - you could have one doctor or provider participate or you could
have all your doctors or anything in between.

(Mary): Okay.

Daniel Green: It's at the individual level and it's based on the NPI tax ID number
combination.

(Mary): Okay. Thank you very much.

Daniel Green: Thank you.

Operator: Thank you. There are no other questions in queue at this time but as a
reminder if you'd like to ask a question please press star and then 1 on your
telephone keypad.

Daniel Green: Why don't we give folks a half minute to decide if they want to ask anything else. If not, I'll turn it back to Mary and Joel to wrap it up.

Operator: It looks like one more question has come into queue again from (Carol Romano) or (unintelligible) from New York.

Woman: (Unintelligible). Thank you all. This has been very helpful. I have one last question. We have not begun PQRI reporting yet so this is still quite new to us. As we begin to implement PQRI reporting who do you think would be best for me to reach out to, to get some, you know, ask some basic questions or go to as I, you know, find that I'm having difficulty even with the basics? Like is there a resource that you would recommend?

Joel Brill: I'll take that one. This is Joel.

Woman: Hi, Joel.

Joel Brill: I would say that there are two resources. Certainly in the CMS perspective there is that page that I mentioned beforehand.

Woman: Right.

Joel Brill: You go to the CMS Web site or you can go to the AGA Web site, www.gastro.org and go into the Center for Quality Activities. And there are a number of resources that are there and if all else failed, you can contact (Debbie Robin) and (Debbie), can I give out your email address?

(Debbie Robin): Actually at the very last slide there's a link to the AGA PQRI site and that will come directly to me so...

Woman: Okay, great. So those questions may be submitted too and that's you, (Debbie)?

(Debbie Robin): Yes.

Woman: Oh, (Debbie), thank you so much. That'll be tremendous.

(Debbie Robin): You're quite welcome.

Operator: Thank you. The next question is from (Cindy Logan) from Texas. Your line is now open.

(Cindy Logan): Yes, I have a question. I'm just following up to (Brandy)'s earlier question and it's on the colorectal screening, the Measure 113. I'm in a GI group. We have physicians that see the patient and plan to do the colonoscopy and they're using the code 3017F for the performed and then no. I guess my question is, if they see the patient, plan to do the screening; that's the code that they're using. They're not seeing the patient back post procedure and coding it at that time. So are they coding that incorrectly? Should they not be reporting that?

Daniel Green: What E&M service are they billing with that visit?

(Cindy Logan): I'm sorry, could you repeat that?

Daniel Green: What CPT code are they billing with that visit?

(Cindy Logan): Oh, the office visit like 99213, 14, just a regular office visit code. And then they're using the 3017F that they're planning to do a colonoscopy but that's the one that they use that says no. It says colorectal cancer screening

performed, yes or no and then if you say no, it's 3017F because they're assuming well, no, it's not performed at this time yet.

Daniel Green: I'm sorry, I don't have my coding book here to answer that question for you.

(Cindy Logan): Okay.

Daniel Green: If you want to give me your phone number I'll call you.

(Cindy Logan): Okay. It's area code 806-793-3141, extension (unintelligible)?

Daniel Green: And your name again please?

(Cindy Logan): It's (Cindy).

Daniel Green: (Cindy).

(Cindy Logan): M-hmm.

Daniel Green: All right, I will give you a call.

(Cindy Logan): Okay. Thank you very much.

Daniel Green: Sure.

Joel Brill: Dan, this is Joel. I know that many of us will appreciate that and I think that one of the concerns that I know all the gastroenterology societies expressed over that measure was that Medicare policy did not allow physician payment for a pre or post procedure E&M visit when that patient was referred for a screening service and therefore the physician was unable to code for an E&M

visit if they performed the screening service whether it's a colonoscopy or another service.

And so hopefully offline we can attain some further clarification on that one with you.

Daniel Green: Thanks, Joel. Actually yes, we have had some folks express their concern over the reimbursement if you will of those visits. Unfortunately that's in an area completely separate. It's a different office from where I work so I can't personally get that information for them. But we'll be happy to try to answer any questions that I can.

And it's a CMS policy division again but that's a little bit, that's in the payment section; we're in the quality reporting section. Not that that helps you guys but part of the issue is that's considered a preventive care measure and then the other issue is, the other part of it is, you know, to have other codes added to the measure if you will, we'd need to go through the measure developer. So if they wanted to add like colonoscopy code to it, it would need to go through the measure developer.

Operator: Thank you. The next question is from (Fran Enright) from Connecticut. Your line is now open.

(Joyce): Hi, this is (Joyce) representing (Fran) and I'm from Gastroenterology Centers of Connecticut and I have three questions and hopefully you'll have three quick answers.

Measure 124, if we have an EMR then wouldn't we always, you know, that's something appropriate for every patient that walks in the door, is that correct?

Daniel Green: That is correct. That's the easiest measure probably in PQRI to report because if you have an EMR and you're using it, that code can go on every claim.

Mary Igo: In our case that just automatically prints on every claim.

(Joyce): Thank you. My second question is, how many GI groups actually participated in 2007? Do you have that number?

Daniel Green: We don't actually have that information. The reports were not broken down for us that way. First of all it's a little bit tricky to tell. Now you would think obviously that somebody reporting on a GI measure would be a GI doctor but that's not necessarily the case. So we don't have that level of specificity.

(Joyce): Okay. My third question is, you're saying that 1.5% of all Medicare charges per individual provider who participated if in fact you met the measures. Is that correct?

Daniel Green: It's 1-1/2% of the covered Medicare Part B charges so if you take care of patients that are in the Medicare Advantage program aka Part C?

(Joyce): Right.

Daniel Green: Those charges would not be included when we consider the incentive payment.

(Joyce): So it's only federal Medicare.

Daniel Green: It's only the Medicare Part B fee for service.

(Joyce): Okay, thank you. You've answered my three.

Daniel Green: Thank you.

Operator: Thank you. The next question is from (Deb Weaver) from Ohio. Your line is now open.

(Deb Weaver): Hi. Yeah, this is (Deb) from Gastrointestinal Associates in Ohio and we were wondering if there are resources for simplifying the paperwork for PQRI system without EMRs. We don't currently have that in the place and we were wondering if we could go to a Web site or if there was a paper system out there that was just simplified for us.

Mary Igo: There is a paper system but there's a coding document that has been put out that has a checklist. It's something that you could attach to your charge ticket for your super bill for the doctors so that if they did a colonoscopy or if they did an EGD they always need to take this sheet on someone over 65. The likelihood of getting at least 80% of your Medicare patients then would be possible.

Dr. Green, do you have any other insight into it?

Daniel Green: The AMA has some educational tools where they had sheets that were printed and it was kind of a little flow chart; does your patient meet this? Kind of like what Mary illustrated from her practice.

(Deb Weaver): Yeah, we have those.

Daniel Green: Okay. Those are a few of the things that I would suggest also in terms of trying to simplify things a bit.

(Amanda), we're coming up close to our conclusion so I guess we could take one more quick question and then we'll have to wrap it up I think.

Operator: All right. The next question is from (Michelle Merritt) from Tennessee. Your line is now open.

(Michelle Merritt): Thank you all very much. We're beginning to start our program in 2009 and I just have a couple of quick questions. On Measure 87 can you also report the HCV (unintelligible) quantitative? Can we do that at other intervals other than at 12 weeks and it not affect the measure?

Joel Brill: Hmm. This is Joel. The measure states that the HCV testing was performed at week 12. That doesn't mean that you had to see the patient at week 12. It just means did you do the testing at week 12?

(Michelle Merritt): Okay because currently my physicians do it at 4 weeks as well so I wanted to make sure that wouldn't affect if we did it at 4 and they repeat again at 12, that it doesn't matter that we're doing it at the 4-week interval as well.

Joel Brill: Four-week intervals should not (unintelligible), that the measure only looks at the week 12 measurement. That was actually - and I'm glad you brought that up because that was a point that was discussed intensively by the measure developers from WASLD at AGA where that measure was first developed.

(Michelle Merritt): And what about if they miss that week and it's really say week 14? Is it that specific that it must, you know, (unintelligible) the patient just doesn't do it specifically then and they go the following week.

Joel Brill: I will admit that I am not as facile and familiar with every precise detail in the measures and would suggest that if I can't locate this in the next 30 seconds

that you look on the CMS Web site that gives you how each measure's specifications are laid out unless, (Debbie), unless you know off the top of your head if there's, you know, what the wiggle room is; if it's 12 or 13 weeks or 14 weeks.

(Debbie Robin): I don't know from CMS' perspective. I do recall that the work group who developed the measure did address that and we can also look at that original development. But I don't know how much of that went into the specifications that are being used by CMS.

(Michelle Merritt): Okay, okay. And do we have time for one more real question on Measure 113, the colorectal screening?

Natalie Highsmith: Sure.

(Michelle Merritt): I was just wondering, you know, we're starting a new open access program where basically our patients are being referred to us, being seen by their primary care and we're just doing the procedure. Do we fall in the guidelines for that or no?

(Debbie Robin): No.

(Michelle Merritt): Okay, I didn't think so.

(Debbie Robin): No. No, you don't.

(Michelle Merritt): Okay. Thank you very much.

Natalie Highsmith: Okay, (Amanda), we have gone a little bit past our 3:30 hour here on the East Coast. I'll turn the call over to Dr. Green for any closing remarks.

Daniel Green: Thank you. I just want to thank everyone today for their participation. There were some great questions answered. Certainly we heard a little bit in the way of frustration from folks that tried to participate in 2007 and they're not falling on deaf ears because we want to make this program as easy for providers as we can and at the same time provide them with accurate feedback that reflects the measures that they and the information that they report to us.

I also want to extend my thanks to Dr. Brill and to Mary Igo for their expert insight and opinion today on today's call and helping certainly to field some of the technical questions particularly with respect to their experience as well as how the measures are constructed.

I believe that the transcript of this call, and anybody feel free to correct me if I'm mistaken, will be available September 30. Thank you so much and please feel free to refer to that. And again please visit our Web site if you have additional questions about PQRI at cms.hhs.gov/PQRI. Again thank you very much for your participation and your interest in PQRI. And thank you, Dr. Brill, and thank you, Mary.

Joel Brill: And I'll just say on behalf of the AGA we'd like to thank our colleagues at CMS for hosting the call, allowing us to participate. Quality's been part of the gastroenterology culture for a number of years. This is one way of implementing it and helping us to adhere to current and future measures that we agree upon but sometimes get overlooked in the busy pressures of practices. It's the start of a long-term process and we'd like to formally thank Dr. Green and his colleagues at CMS for making this happen.

Daniel Green: Thank you.

Mary Igo: Thanks, everybody.

Natalie Highsmith: Thank you all again for joining us. (Amanda), can you tell us how many people joined us on the phones?

Operator: It looks like the top number was 127.

Natalie Highsmith: One hundred twenty-seven. Thank you, everyone.

Daniel Green: (Amanda), was there anybody in queue at the end?

Operator: No, there was not.

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

Natalie Highsmith: Thank you.

Operator: You're welcome.

END