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Centers for Medicare & Medicaid Services

Moderator: Barbara Cebuhar
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Operator: Good afternoon. My name is (Adam) and I'll be your conference facilitator today. At this time I would like to welcome everyone to the Physicians' Quality Reporting Systems Special Open Door Forum. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there'll be question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you. Ms. Cebuhar, you may now begin your conference.

Barbara Cebuhar: Good afternoon and thank you, (Adam). Welcome to the Special Open Door Forum for the Physicians' Quality Reporting System and the Electronic Prescribing Initiative Program. My name is Barbara Cebuhar and I work in the Office of External Affairs here at CMS. We are pleased to have a number of guests with us today.

I'd like to introduce Dr. Michael O'Dell, who's with the Truman Medical Center at – in Kansas City, Missouri, Dr. Tamara Sobel, who's with the Crossroads Internal Medicine practice in Owings Mills, Maryland, and then we have Jud Neal, who's the president and CEO of Physician's Business Network in Kansas City, Missouri, who will be sharing their success stories on the Physicians' Quality Reporting System and the e – the Electronic Prescribing Initiative program.

The transcript and the audio for this special open-door forum will be posted at a later date, on the sponsored calls page, in the download section at, and I'm going to read a Web link; it's http://www.cms.gov/pqrs/04_cmssponsoredcalls

. That'll get you to the page where we have the transcript, as well as the recording of the item and it'll probably be available in about two weeks.

Now I'd like to introduce our subject matter experts from the Office of Clinical Standards and Quality. First, we'll here from Lauren Fuentes and Diane Stern, who will provide some announcements that I know stand to affect many of you. Secondly, Dr. Sobel, Dr. O'Dell and Jud Neal will present their respective experiences and insights about PQRS. Finally, we will take your questions for the presenters at the end of the presentations.

Just a reminder, if you need assistance with the Physicians' Quality Reporting Program, you can call the QualityNet help desk at 866-288-8912. That's available from 7:00 am to 7:00 pm Central Daylight Time, Monday through Friday, or you can write an e-mail to qnetsupport@sdps.org , or you can call the TTY number at 877-715-6222. We are very grateful for your joining the call today and, Lauren, do you want to go ahead with your announcements?

Lauren Fuentes: Thanks, Barb. Our first announcement is regarding the payment adjustments. In November, the Centers for Medicare and Medicaid Services announced that beginning 2012, eligible professionals who are not successful electronic providers may be subject to a payment adjustment on their Medicare Part B Physician Fee Schedule, Covered Professional Services. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 authorizes CMS to apply this payment adjustment, whether or not the eligible profession is planning to participate in the E-Prescribing Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99 percent of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5 percent of their Medicare Part B PFS covered professional services for not being a successful electronic prescriber in 2011 or as defined in the future regulation.

In 2014, the payment adjustment for not being a successful electronic prescriber is two percent, resulting in an eligible professional or group practice receiving 98 percent of their Medicare Part B PFS Covered Professional Services. The payment adjustment does not apply if less than 10 percent of an eligible professional or group practices allowed charges for the January 1st, 2011 through June 30th, 2011 reporting period are comprised of codes and a denominator of the 2011 ERX measure. Please note that earning and incentive and (year X) incentive for 2011 will not necessarily exempt an eligible professional or group practice from the payment adjustment in 2011.

Our second announcement for today is regarding the QualityNet help desk. We would like to remind anyone who contacts the help desk that certain demographic information is required in order for tickets to be processed in a timely fashion. When calling or contacting the help desk, please be sure to provide a name, e-mail, phone, address and description of the issue. Again, this information is absolutely necessary for ticket processing and will be verified each and every time you contact the help desk. Please note, this information will remain confidential and will only be used for the purpose of ticket remedies.

And our last announcement for today is regarding the URL change. In the calendar year 2011, Medicare Physician Fee Schedule Final Rule that was published in the federal register on November 29th, 2010, the Centers for Medicare and Medicaid Services announced that we were renaming the Physician Quality Reporting Initiative, or PQRI to Physician Quality Reporting System. As part of the name change, we have updated the Physician Quality Reporting System's Web site address. The new Web site address is http://www.cms.gov/prqs . The previous URL address, cms.gov/pqri will automatically redirect to the new Web site address. Please note that documents and language that currently have the PQRI name listed will continue to be changed over time to reflect the new name. Thanks.

Next, Diane will provide us with some upcoming calls and meeting dates.

Diane Stern: Our next national provider call will be held on April 19th, from 1:30 to 3:00 pm Eastern Time. We'll have a national provider call on May 17th, 1:30 pm

to 3:00 pm, and a special open-door forum will be held on May 26th, 2:30 to 3:30. And the April 19th national provider call registration information has been posted to the PQRS Web site and I'll give you that Web address again. It's http://www.cms.gov/pqrs . Thank you.

(Barbara Cebuhar): Thanks, Diane. Now we're ready to hear from our first presenter, Dr. O'Dell.

Dr. Michael O'Dell: Hi, I sure appreciate being able to join the call today and I hope my comments will be helpful to all that are listening in. I'm going to really concentrate on my prior practice, although I'll slip in some comments about my current practice. My prior practice was with North Mississippi Medical Center in Northeast Mississippi, primarily at Tupelo. I'm now at Truman Medical Center, which is a safety net provider, so I've got a little bit of mix of both practices that I hope I can share with you today.

In terms of the Northeast Mississippi practice, the direct practice I was in had about 12,000 patients in the practice, although for the system itself, we were somewhere in the neighborhood of 350 to 400,000 patients in our system. The system in Northeast Mississippi was a large rural hospital system, 650-bed hospital with six affiliate hospitals, 38 clinics, and took care of roughly a quarter of Mississippi. My current system, Truman Medical Center is a safety net hospital in Kansas City, Missouri that has roughly 130,000 patients that are divided between our two hospitals in the system. At Northeast – or North Mississippi Medical Center, we had – in the direct practice (office), (we've had) 18 (residences residency) program, six faculty.

In the system as a whole, there was about 60 primary care providers in that system that were employed by the system. And again, still at North Mississippi, we really didn't have a large number of support staff at our building, per se. In our back office, or business office, if you want to call it that, we had four direct support staff in that office, but we did have a very robust and separate billing office. At North Mississippi, we had roughly 32 percent of our Medicare population in our – in our – comprised our patient base. Our billing system was a bit of a hybrid. We had a electronic medical record, but we used a freestanding system for our billing and so we ended up

having to use paper to complete the visit, in terms of translating the clinical visit into a billing document in order to actually submit bills.

We started working on PQRI very early on, in part because of involvement through the American Academy of Family Physicians and others. I was in leadership positions in the American Academy of Family Physician as the eventual chairman of the Commission on Quality and Practice for that organization and was very active under state organization as well and so we really heard a lot about the PQRI initiative through those various agencies and through organized medicine. The ERX was a little bit later in all that, obviously, but was certainly – again, the information was transmitted largely through the academy, but obviously with great support from CMS and other folks, in terms of trying to get information out to us.

In terms of our experience with PQRI and electronic prescribing, we started the PQRI basically in the first year that it was available for quality reporting. We really didn't jump on the eRx bandwagon initially; in large part because of our local pharmacies weren't really capable of receiving that data at the – at the time and we had some admitted technical issues with our own computer system. But in the last year and as I was leaving, they were beginning to actually do eRx as well.

(In) our outset, we were I think fairly successful with PQRI and I'll describe how we were doing that, but we were reasonably successful and I think we had reasonably good reporting, although it certainly wasn't 100 percent of what I would have liked it to have been. In part, because of that, we had a reimbursement for that activity was not as much as – of course, everybody hopes for the maximum amount and we didn't get the amount. But frankly, I think that was largely due to some hiccups we were having in terms of getting a system going for reporting.

We started off, as I mentioned, with a paper system. When a physician would finish seeing a patient, they would market the appropriate places on our paper billing document and as that went up to our back desk, our checkout desk, then that would get translated into the various things that we needed to communicate with the CMS and transmit that on. And not necessarily to

solve the PQRI problem, but because we wanted to be demonstrating high quality of care, we moved to certification under NCQA as a diabetes provider of excellence and were able to achieve that recognition within about a year or two after we started the PQRI.

And unfortunately, in our larger system, which supported our billing office, that didn't necessarily translate into any additional ease of use for reporting to CMS. Our billing system needed to support those 38 other offices and so we remained with a paper-based system until shortly before I was leaving. About a year and a half ago, we migrated that system to actually a registry-based system, using a registry product called Meridios and that automated a lot of our reporting and obviously made it much more robust and much easier for the physicians. It took some of the responsibility for documenting the PQRI activities and actually automated and it has made the reporting much more robust.

We chose diabetes as our specific measure, in large part because when we ran billing codes on our population, what we found was that that was the most frequent diagnosis and certainly affected the highest number of patients in the population we were serving and so we mainly went after the diabetes measures in PQRI. With the onset of using a registry, we were able to start reporting more measures and I think that's been very helpful to have that registry function.

We used – our primary interest in PQRI was actually kind of an add-on to the quality work we were already doing. We were very interested in demonstrating high quality and the PQRI was a bit of a bonus for us on that. And so we were already internally using our reporting measures for some of the diabetes work that we were working on.

Just going through some other things I can think of to tell you all, we again used our billing data to determine our internal population. We had a fair number of resources available to us at the clinic sites. We have a pharmacist onsite and he was very engaged in diabetes work. We had access to a diabetes educator; that was very useful to us. We had a wonderful nursing staff that was very eager to serve the patient population we were serving and they were

very helpful in terms of patient education and improving our overall care of diabetics. So we really had a nice situation in terms of being able to use work we were doing in terms of quality and apply that to our PQRI experience.

The feedback reports were mailed to our billing office. That caused a little bit of confusion initially, because we were all wondering how we were doing on our PQRI and the billing office received the reports and weren't immediately certain of how to distribute them. That was an internal issue for us. We got that straightened out and were able to actually begin getting the reports directly to the providers and that feedback was helpful to the providers in terms of their performance.

I'm trying to think of other things I might share. I guess at my current practice at Truman Medical Center, again, a safety net hospital; we have a lower percentage of patients that are Medicare-eligible patients. With North Mississippi, it was about 32 percent; here we're closer to 20 percent. Nonetheless, we're participating in PQRI. We're actually back to more the paper-based system that I was initially used to at North Mississippi Health Services, but exploring some registry systems through our computer provider, which is Cerner here at North Mississippi, or at – excuse me; at Truman Medical Center.

All in all, I think the PQRI is a nice augment to work that physicians are already interested in doing in terms of improving the quality of their care and a useful adjunct and it's always nice to add payment on top of quality improvement efforts that underway. So with that, I think I'll let other speakers talk, but that's been my experience and be happy to fill in any questions that people have at the appropriate time.

Barbara Cebuhar: Thank you very much, Dr. O'Dell. And our next speaker is Dr. Tamara Sobel of Crossroads Internal Medicine in Owings Mills, Maryland. Dr. Sobel, could you go ahead and go please?

Dr. Tamara Sobel: I'd like to first thank you for inviting me to speak about my experiences with e-prescribing. I'd like to tell you a little bit about me and my practice. First of all, you know my name. I am an internist. We practice in Owings Mills,

Maryland. There's a practice, currently of two physicians and one nurse practitioner and we have about 6,000 patients. Prior to this time, we had about – we had four doctors and one nurse practitioner, but that changed in July of 2009, when the two other physicians decided to do other – they had other opportunities.

We have currently three medical assistants, one medical records person, two receptionists and one billing person and prior to July of 2009 our billing was done in-house and now we use a billing service. We have approximately 20 percent Medicare patients and we started e-prescribing in about 2006. We were a pilot project through Blue Cross Blue Shield and we use a system called Rcopia, so that was a little program through our computer. And we did not have a integrated medical record at that time; we had a homegrown record where we sort of – we had to log into the Rcopia every time we wanted to e-prescribe.

We heard about the e-prescribing program and reporting through the AMA News and other journals and we decided that we wanted to participate because we saw the benefits of e-prescribing and we realized eventually it would be mandatory, so we thought we would get started. We first started reporting in 2009 and were successful the first year. Since that time you know it's only been two years, what we – what has happened is we now have a medical record that has the e-prescribing integrated, so it's much – makes it much, much easier.

When we first implemented the e-prescribing, we have a paper form that we fill out with all the coding, after we see the patients, and there is a code, the GA553 code for the e-prescribing that we would circle and our billing person would then enter that code. We you know educated our billing person, who then looked on the Web site and found out how to do it. It was not difficult at all. We did an – we did an extra training in our office. I will say that I typically am not a real computer person and I was a little anxious at first about e-prescribing, but it was very simple and as soon as I started doing it, I realized how easy it was and especially with prescription refills and the accuracy of prescriptions, things get immediately to the pharmacy (are) at least definitely very beneficial.

Let's see; as far as the feedback report, the way that I got it is I called the carrier and I requested it. It took about a month for me to get it. I did keep track of the patients that e-prescribed on and I still do it, which is probably a little overkill, but every time I e-prescribe, which I now do directly from my medical record, I keep a little notepad with every single patient and the day that I did, just to make sure that I've done enough. So that's my little way. It's probably overkill; it's not necessary.

Let's see; as far as lessons learned from the e-prescribing system, really it was just a little learning curve, not difficult, and once it was in place, it was a real time-saver. It's convenient – it's convenient for the patients. Patients really like when you're in a room with them and you e-prescribe and say the prescriptions (in) the pharmacy and they don't have to take anything with them, so that's really been a very big plus. There's definitely less errors. Some physicians have handwriting that's very illegible and the e-prescribing really takes care of that problem.

And also, what I like about the e-prescribing system is that when you type in a medication, if it – if it's – it brings in all the other medications the patient's on and checks for drug interactions and (it will also) determine if the medication is on the patient's formulary, which is – which is definitely beneficial. And what else can I say? I guess the only criticism that I would have; it's really not a criticism. It's really a wish.

I wish that it was easier and I know that it can't – it can't be done due to – due to there's definitely regulations against this, but Medicare could directly at prescription activity through the e-prescribing system, rather than us having to enter the code on the paper and then you know be dependent on our coding person to then submit it, so there's two other opportunities for errors for us not to get the correct code submitted so that they wouldn't know if we're prescribing for the right amount of patients. I think that it would better. I know that they can't, but it is a wish.

So that's pretty much all I have to say. If you know if anyone has any questions; I just wanted to thank you again for having me.

Barbara Cebuhar: Thank you very much, Dr. Sobel. And I would like to introduce our third speaker and all of them will be available for questions when doctor – Jud Neal finishes his presentation. Jud Neal is the president and CEO of Physician's Business Network in Kansas City, Missouri. Jud, would you go ahead and offer your insights?

Jud Neal: Thanks, Barbara. First of all, let me thank you for having me on this call. PBN, as Barbara said, is based in Kansas City. We are a third-party billing company that provides billing services for office-based physicians, as well as hospital-based physicians. We own our own proprietary software system and we'll talk a little bit more about that in a couple of minutes. We provide billing in about 21 states, so we deal with various MACs of CMS and payers of commercial and governmental payers, Medicaid and so forth. We provide billing services for about 400 providers; mostly physicians, but also others that are eligible for reimbursement, such as CRNAs for anesthesia.

We actually have been participating in the PQRS initiative, if you wish, since 2007. I think that may have been the first year it started. Our reason for participating is we saw as it a precursor to pay-for-performance or P-for-P, I think, which was the terminology used at the time. And we saw it as a way to learn and understand and debug the system and participate in process, as we saw that pay-per-performance as a way to measure quality and so forth, so we felt we needed to say on it and work on it.

I would say that we had to help sell or help the physicians or our clients understand what was being done and why it was being done. In some cases, they may or may not have understood the amount of money that they may have realized, once they understood that this was a process and frankly, the first of the process. We had universal participation. I believe that, if I'm not mistaken, almost all of our clients, if not all of our clients, are – have been and are participating in the PQRI/S program.

We gained our knowledge originally, obviously from CMS and we also relied on the various specialties that we are involved in, anesthesia, radiology, surgery, orthopedics and so forth; to learn about what was going to take place. But I would say that we relied most heavily on the tools that were available at

CMS. We assisted the physicians, if the (only) could come up with three measurements or whatever number of measurements that were – that they were eligible for. It was pretty straightforward; in those practices where more measurements could be chosen, then we would dialog with them and of course help them decide what they want to measure.

We capture almost all of our information electronically, using this proprietary software system, and therefore we could rewrite the program as necessary in order to catch the measurements and report the measurements as the PQRI moved down in its evolution and that was fairly easy for us, because we weren't relying on a vendor to change our software system and relied minimally on paper at all.

The – in the beginning, I would say our success rate was variable. Some were very successful and we were able to capture the data that we needed very successfully. It was because (the) systems issues or it may have been because of physician or provider participation and documentation and so forth. So I think that we experienced variable success rates on it and as we gain more knowledge and learn more, we put additional systems edits in to make sure that we captured what we needed to capture.

I think Dr. O'Dell mentioned the concept of the registry. In the original process, we were submitting claims directly, on a claims basis, directly to CMS and we were not as successful and consistent. We – it was a little strange to us that we would submit the same information for two different practices and may or may not be successful. And so we have relied more toward – this period of time I think we moved to the registry more and more. In 2009, we were more to registry. I think Dr. O'Dell talked about that a little bit.

They – I think the important thing is to make sure that people get trained and use the resources that either the society of the specialty or from CMS; that's where we also learned much of our information and I think that's been touched on. The other thing that I'd – I would mention is that we are now trying to get the feedback. It sounds like, from the other speakers, that's not as much of an issue, but for our clients, we would like to be able to go in get

the feedback report for our clients and furnish it, since we're a service organization for the physician. And the current system is set up so that the individual physician is the one that has to go in and get the – it's our understanding anyway, to get the individual feedback and we can't go get that. And our physicians have had some various success on getting that feedback. Even two physicians in the same practice may be able to get their feedback reports and the other ones may not.

And I think overall, the most important part, I think the lesson learned of all this, again, because of – we think it's a precursor to the pay-for-performance and the whole quality process that Medicare is trying implement, is to learn an educate – constant education and tenacity and don't give up and just keep working on it. And that's why we've participated as long as we have, because it's a – it's a fairly complicated process and it's going to keep evolving, so I would encourage everybody to learn and read and listen and don't give up on it; just keep working on it. And I would encourage people to use (the) register as much as possible.

Barbara Cebuhar: Thank you, Mr. Neal. (Adam), I think if you could instruct people how to get into the queue for questions that would be great. We have Dr. O'Dell, Dr. Sobel and Jud Neal available for questions.

Operator: And at this time I'd like to remind everyone, if you'd like to ask a question, you may press star and then the number one on your telephone keypad. And we'll pause for just a moment to compile the Q&A roster.

And your first question comes from the line of (Jennifer Montgomery). Your line is open.

(Jennifer Montgomery): Hi, thank you. I'm not sure who there can answer the question, but we have providers who've just started using an electronic health record and they've started submitting prescriptions electronically and they're a bit confused, because they want to participate in the Medicare EHS incentive and they think they can't do both. While they realize that they would not receive an incentive for the ERX, aren't they obligated to do this, since it's going to be mandatory?

Christine Estella: The e-prescribing incentive program is …

Dr. Dan Green: (Inaudible) …

Christine Estella: I would speak behalf of this. The e-prescribing incentive program is voluntary; however, if you're not a successful e-prescriber for 20 – for the 2011 reporting period, for purposes of the 2012 payment adjustment, you are going to get dinged that one percent.

(Jennifer Montgomery): Right, so they theoretically should do it, even though – if – do you know if you – if you're going for the Medicare electronic medical record incentive; would they pay that and not give the incentive for the ERX, but you'd still be obligated to do it? I – that's you know it's kind of …

Christine Estella: Yes. If you met – if you're talking about the Medicare EHR incentive program; right?

(Jennifer Montgomery): Right.

Christine Estella: If you meet the meaningful use requirements for that, I think that's a larger payment, so you would get the larger one. So yes, you would get the incentive for that and then you would get out of the 2012 payment adjustment if you met our successful e-prescribing criteria.

Dr. Dan Green: So if I may clarify that just a little bit; so if you – if you sign up for – register for the meaningful use and you are a successful meaningful user …

(Jennifer Montgomery): Right.

Dr. Dan Green: … for Medicare, you will get the Medicare incentive, regardless of which is larger. You – typically, for the average professional, that would be the much larger incentive.

(Jennifer Montgomery): Yes.

Dr. Dan Green: And you would – and your provider would get that incentive. However, as (Christine) also said, you do need to submit 10 subscriptions or – report to us on claims that you've e-prescribed for 10 Medicare beneficiaries in the first

six months of 2011 to avoid a 2012 payment adjustment. Furthermore, if you report to us through the e-prescribing program that you submitted 25 electronic prescriptions during the course of this year, you would also be exempt from the 2013 ERX payment adjustment.

So 10 via claims in the first six months; when I say via claims, obviously that's (what) reporting the G code does.

(Jennifer Montgomery): Right.

Dr. Dan Green: Twenty-five total for the year, so if they do, let's say 12 in the first six months and then 13 in the remaining six months, they would be – they'd be fine for the – for the year and they would also be exempt for (the) 2013 year; correct? They would not get two incentive payments, however.

(Jennifer Montgomery): OK and if I can just expand a little bit, can you give me a scenario where somebody wouldn't be eligible in 2012, if they didn't do the 10 required for the first half of this year?

Dr. Dan Green: When you say not eligible, you mean for the payment adjustment?

(Jennifer Montgomery): Yes, because I keep getting the e-mails from CMS saying you know it doesn't guarantee that you will – doing 10 will not guarantee you getting the exemption for 2012.

Dr. Dan Green: So if you do 10 – if you do 10 e-prescribing instances in the first six months of 2011 …

(Jennifer Montgomery): Right.

Dr. Dan Green: … and you report those to us on claims; I think the claims have to be received by the middle of July, but sometime in July, you will – you'll be exempt from the 2012 payment adjustment. Now obviously, those 10 e-prescribing events have to be for services that appear in the denominator of the measure.

(Jennifer Montgomery): Right, OK.

Dr. Dan Green: But you would be exempt. There are other ways to avoid the payment adjustment, which would include if you don't have charges that – if your total Medicare charges are not such that they're comprised at least of 10 percent of the codes that appear in the denominator of the measure. If you have fewer than 100 denominator-eligible events in the first six months of 2011, you would automatically be exempted. If you don't – there's a G code you can report if you don't have prescribing privileges and there are two other G codes you can report for – if you practice in a rural area without high-speed Internet or if you practice in an area that doesn't have pharmacies that accept electronic prescriptions.

(Jennifer Montgomery): OK. Thank you very much. That was very helpful.

Dr. Dan Green: You're welcome.

Barbara Cebuhar: Thank you very much, (Jennifer). Our next question please, (Adam).

Operator: And your next question comes from the line of (Kim Baker). Your line's open.

(Kim Baker): Hi. My question is with PQRS. We are just starting to do this and is there a report that we will have to print out from our electronic system to send to Medicare or is it just what we send – put the measure codes in? Just like the (RXes), they will you know pick this up?

Molly MacHarris: No. For reporting for the Physician Quality Reporting System you have a variety of options. You can report via claim.

(Kim Baker): OK.

Molly MacHarris: And reporting via claims; that would require you to report G codes on the claim where the service was rendered.

(Kim Baker): OK.

Molly MacHarris :Another option is registry reporting, which some of the doctors spoke about before.

(Kim Baker): Right, OK.

Molly MacHarris: And we will have a list of qualified registries up on our Web site within the next few months that you can take a look at. We also have an EHR-based reporting option and we do have a list of our qualified EHR vendors that's available on our Web site. So if you have one of their qualified systems and products, you would just need to update your medical records throughout the year. And then in January through March of 2012, you would submit your data to us.

And then we also have a GPRO option, so for reporting through the GPRO, you would have needed to self-nominate as part of a group practice. We have two types of GPROs for 2011. We have GPRO1, which is for the large group, which is (110) with 200 or more (NTIs) and then we have GPRO2, which is for smaller groups between 2 to 199 (NTIs).

(Kim Baker): And more question, when we're doing this reporting, how long before we can get feedback on how we're doing?

Molly MacHarris: So you will need to report whichever you mechanism you decide to do through either throughout 2011 via claims or if you do registry or EHR reporting; that data would come into us in January through March of 2012.

(Kim Baker): OK.

Molly MacHarris: So we typically process our payment and feedback around the summer to fall of the following year. So for our 2011 program, you can expect to receive a feedback report and a payment, if you are considered incentive-eligible, around summer to fall of 2012. And again, those dates are subject to change, but that's around the times that we've had them in the past.

(Kim Baker): All right, thank you. You've answered by questions.

Barbara Cebuhar: Thank you, Ms. (Baker). Our next question please, (Adam).

Operator: And your next question comes from the line of (Phyllis Hilliard). Your line is open.

(Phyllis Hilliard): Hi. I actually have two questions. One is you've discussed – I can't remember who; the registry reporting and we've been having trouble getting information in ophthalmology as to if there is anybody that, if doing that registry, if there's a cost involved and how much labor it takes to get the documentation to the registry in order to report successfully.

Molly MacHarris: For registry reporting, we don't have our list of qualified registries for our 2011 program available yet. We do have – hope to have that available within the next month or so. You can, however, take a look at our 2010 – for our 2010 program, our list of registry. There are – there were around 95 or so for 2010. We anticipate having around that number for 2011. But, so what you would want to do is when that list of qualified registries is available is take a look at that and we qualify the registries based off of specific measures and measure group, so if there's a specific ophthalmology measure you would want a report on, you would want to make sure that you contact a registry that is qualified to report on that.

And depending on which registry you work with, some do have costs involved for reporting through them; some don't. We have quite a few registries that are also EHR vendors, so it could be a no-cost charge if you already have their product. But we will have that list available soon, which will have their contact information and the measures that they will be reporting on.

(Phyllis Hilliard): OK, my second question was how soon after the reporting year, like for 2010? Can we contact our carrier now and get our report?

Molly MacHarris: Are you speaking for your 2010 payments and feedback report?

(Phyllis Hilliard): Well we've actually done 2010 and 20 – excuse me; we've done PQRI, which is now S, and we did ERX. We received payments, but we're having trouble isolating you know who did and who didn't, so we want the report. So after you get the check, can I assume I can contact the carrier then for (my) report?

Molly MacHarris: Yes. And just to clarify; we haven't yet issued our payment or feedback for our 2010 program. Again, we hope to be doing that around the summer to fall of this year, but we have issued our 2009 payment and feedback. And you have two options to get your feedback report; you can call the carrier MAC

and you can get your (NPI)-level feedback report or you can contact – I'm sorry; you can get an IAC account and through our PQRS portal, you can obtain your (10-level) feedback report, which has it broken down by (NPI).

But if you have additional questions on this, we also have a help desk that can help you with this information. And the number for our help desk; it's the QualityNet help desk and they're available from 7:00 am to 7:00 pm Central Standard Time, Monday through Friday. And their number is 866-288-8912 and they will help you determine which is the best option for you for accessing your feedback report and they'll walk you through the process.

(Phyllis Hilliard): OK, thank you.

Barbara Cebuhar: Thank you, Ms. (Hilliard). Our next question please, (Adam).

Operator: And you next question comes from the line of (Andrea Phillips). Your line is open.

Dr. (Andrea Phillips): Hi. This is Dr. (Andrea Phillips) and I hail from the state of Mississippi, where Dr. O'Dell was until recently. My question is for those of us in small solo practices, starting from ground zero, who are, like Dr. Sobel referred to herself, not so you know e-savvy; how we identify an ERX program that would suit our size and lack of, again, experience with electronic health records and so forth?

Dr. Dan Green I'm going to answer the first part of that question, then I'll turn it over to Dr. Sobel. For a listing of at least some of the available e-prescribing programs, (go) on the SureScripts-RxHub Web site; SureScripts is all one word. They'll have a list of the e-prescribing systems that are approved to use their system. And from there you could contact the vendors to get information about capabilities and pricing.

You know depending on what your future plans are with respect to implementation of a full EHR, certainly we would encourage you to look at the ONC, Office of the National Coordinator Web site to see a you know fully functional and ONC-certified electronic health record. And the only reason I suggest that is if you're going to be doing EHR in the future, you may

consider looking at an integrated program, or at least a program that has – that is partnered with a standalone e-prescribing system.

So if you – if you look at one that's partnered with a standalone e-prescribing system you know it may be that you could buy the e-prescribing system now and then add the full EHR, if you're not ready to implement both at the same time, you could add that part in the future. But I'll turn it over to Dr. Sobel also, for some input in terms of small practices determining EHR – e-prescribing; excuse me.

Dr. Tamara Sobel: Yes, hi. I was going to say that we started out as a pilot program through Blue Cross Blue Shield and they actually encouraged us to use this – it's called Dr. First Rcopia. And it's very easy to use. You can – you contract, I think it's year-by-year and I would definitely say look into that one, because it's definitely easy; it's easy. And all the ones through SureScripts are – (that's) – they all go through SureScripts; they're all approved through SureScripts. So and then you – the other thing that you can do is you can call your hospital and see if they have an e-prescribing system. That's another idea and maybe you could use that.

Dr. (Andrea Phillips): Do you have any trouble interfacing with the small independent pharmacies?

Dr. Tamara Sobel: No, not at all. They're actually – they all – pretty much every single pharmacy that I've used participates.

Dr. Dan Green The small – just to also follow up on that, a lot of the smaller pharmacies, if they don't accept electronic prescribing currently, when the transcription is transmitted over the – it's typically over 90 percent of them are transmitted over the SureScripts RxHub network. If they know that the pharmacy's unable to receive electronic prescriptions, it – they convert it to a fax. And you – but you still get credit for e-prescribing, because as far as you're concerned, if you're using a qualified e-prescribing system, you have e-prescribed.

Barbara Cebuhar: Dr. (Philips), does that answer your question?

Dr. (Andrea Phillips): All right, just from Dr. Sobel, I want to confirm that Web site was drfirst (r) …

Dr. Tamara Sobel: Yes, it's drfirst. It's – you can – you can contact – I just looked it up on my computer; it says sales@doctorfirst.com .

Dr. (Andrea Phillips): OK.

Barbara Cebuhar: Thank you very much, Dr. Sobel, Dr. (Green) and Dr. (Philips). Our next question please, (Adam).

Operator: And your next question comes from the line of (Brenda) Beckwith. Your line is open.

(Brenda) Beckwith: Hi, good afternoon. We have a (sport team) physician practice. One of our physicians is a sleep specialty who does not prescribe medicines. He prescribes CPAPs, which is I guess more of a DME and our question is how are we going to avoid these payment adjustments when you have a physician that does not prescribe? We are – all of our other physicians are fully e-prescribing; we are full electronic charts. We have no issues with that. We just happen to have a physician that does not prescribe medicines.

Dr. Dan Green One thing that – but does he have prescribing privileges, (I guess)?

(Brenda) Beckwith: Yes, he does. He just considers having to give medicine a treatment failure if he's having to prescribe sleeping pills or something like that and he really is just simply a sleep specialist doctor, so.

Dr. Dan Green Does he bill Medicare the (nine) – the ENM codes that are in the measure?

(Brenda) Beckwith: Yes, he does. He does – he does see patients and he …

Dr. Dan Green Right, but again, I'm not familiar with how sleep professionals bill.

(Brenda) Beckwith: Yes, (but) our practice is a cardiology practice and we do have a – two sleep labs, so when we have patients that have sleep issues, they will see him specifically for those sleep issues.

Dr. Dan Green Right and I understand that, but what I'm getting it as part of the requirements to be subject to a payment adjustment is that 10 percent or more of your charges have to be comprised of codes that are in the denominator of the measure, which for – which for a typical medical doctor would be things like your 99211s through 215s.

(Brenda) Beckwith: Yes, yes.

Dr. Dan Green Your 201s through 205s.

(Brenda) Beckwith: And that is what he does; yes.

Dr. Dan Green OK, so the sleep studies themselves are a different code, I imagine; right?

(Brenda) Beckwith: (That's complete) – that's completely separate, yes.

Dr. Dan Green But still 10 (percent are of the – are ENM) visits.

(Brenda) Beckwith: (Completely separate). Right.

Dr. Dan Green Now where does he send the prescription for the CPAP in? Is it through a pharmacist?

(Brenda) Beckwith: I believe those are DMEs; yes. I don't know that they go to a pharmacy. I think they go to – I think those are more DME; they're machines.

Dr. Dan Green): No, I understand that part, but I guess – yes, I was wondering if there's a medical pharmacy that would accept those.

(Brenda) Beckwith: Oh, I don't know. Would that, at this point, as far as you know, be the only thing we could do? We're a little concerned, because at this point, there's not prescriptions.

Dr. Dan Green I can appreciate your – I can appreciate your dilemma.

(Brenda) Beckwith: Yes.

Dr. Dan Green Is there somebody from the help desk on?

Help Desk: We're here, Dr. (Green).

Dr. (Green): OK, could you take this person's name and number and maybe open a help desk ticket and we'll be in touch?

Help Desk: Absolutely. Can I have your name and number, ma'am?

(Brenda) Beckwith: Yes. It's (Brenda) Beckwith; the last name, B as in boy, E C K W I T H.

Help Desk: And your phone number please?

(Brenda) Beckwith: It's area code 904-493-3341.

Help Desk: Alright, (Brenda), we'll be in contact with you, ma'am.

(Brenda) Beckwith: That is fabulous. Thank you so much.

Barbara Cebuhar: Thank you. And, (Adam), our next question please.

Operator: And your next question comes from the line of (Tammy Kinney). Your line is open.

(Tammy Kinney): Hi. I work for a podiatrist and he is mostly a surgical-based practice. Well he's having a hard time meeting the (TAD)-required e-prescribe opportunities, because he's not giving a prescription at the time of the visit, when a patient first comes to him. He's giving it after the surgery is performed, so it's not a reporting opportunity.

I have heard from different entities that we are able to e-prescribe over-the-counters, so if they are prescribing like, say anti-inflammatory over-the-counter med at that first visit before the surgery occurs; does that count for reporting the G code for the e-prescribe?

Dr. Dan Green: So the question is to whom would then send this over-the-counter medication prescription to?

(Tammy Kinney): Well of course the pharmacy.

Dr. Dan Green: Well I guess …

(Tammy Kinney): (Quality has says) that this counts and one of the regional CMS offices says no, so I want clarification.

Dr. Dan Green: Right. I've actually received that question, perhaps from your regional office. And the issue is you know we define electronic prescribing as electronic communication, basically between the physician or eligible professional and a pharmacy and potentially with a pharmacy benefit manager or payer you know depending on the person's insurance, et cetera.

(Tammy Kinney): (Yes, sir).

Dr. Dan Green: So if you are sending a prescription, be it for you know if you're prescribing Motrin you know 400 milligrams, which as you know can be given – is the same thing as – I should say Ibuprofen 400 milligrams, which as you know is the same thing as Motrin IB, and you're sending that into the pharmacist you know with all the bells and whistles in terms of if there were some sort of drug interaction it would alert to you, then yes; then that would count.

(Tammy Kinney): Oh, OK.

Dr. Dan Green: But again, the way the – if you're simply send you know saying to the patient, here; go get you know some Pepto-Bismol and you're you know typing into your computer you know dispense Pepto-Bismol, but it's not going anywhere; that would not count.

(Tammy Kinney): OK, OK.

Dr. Dan Green: So we'll need to – we'll need to try to clarify that and, folks at the help desk or Lauren or Diane, we'll need to probably come up with an FAQ for that, because again, if it's between a doctor and a – and a pharmacy, we're OK with that. But if it's not specifically the communication then it's not OK.

(Tammy Kinney): Oh no, absolutely. You know so there are several opportunities where they say to the patient they want them to take an over-the-counter type anti-inflammatory and they'll give that type of information, so that was when it

came up. Somebody told us that they could actually transmit that and I wanted to confirm with you guys before I give them the go-ahead.

Dr. Dan Green: Right and again, previously I think we likely said that you could not, because again, we were trying to figure out how you would have the transmission part when it's an over-the-counter medication, because typically pharmacists – pharmacies don't often fill over-the-counter medications. It's you know obviously more for regular prescriptions.

(Tammy Kinney): Absolutely, OK.

Barbara Cebuhar: Thanks, (Tammy). I think we've got time for one or two more questions; (Adam)?

Operator: And your next question comes from the line of (Pamela Phillips). Your line is open.

(Pamela Phillips): Thank you. I represent the Society for Vascular Surgery and I just want to be clear in terms of the payment adjustments for the e-prescribing, which, as described by a previous caller, is – it's problematic for vascular surgeons, because they do not prescribe medication very much. But if I understand it, they must prescribe 10 prescriptions between January 1 and June 30th of this year. If they are not able to do that, they get payment adjustments in 2012, '13 and '14. Is that correct?

Dr. Dan Green: Well, they definitely will get a payment adjustment in 2012 of one percent. And their payment adjustments are also legislatively directed for 2013 and ('14).

(Pamela Phillips): Right.

Dr. Dan Green: We've stated that you can get out of a payment adjustment in 2013 by being a successful, quote, unquote, e-prescriber in 2011, which means the 25 prescriptions during the course of the year. However, we are in the process of our rulemaking so of course we can't discuss any more details, but there may be other opportunities and ways for eligible professionals to avoid penalties in

future years, meaning 2013 and 2014. And if you know if that's the case, it would be the subject of rulemaking.

(Pamela Phillips): OK. So you would – are you looking at, like vascular surgeons, who rarely prescribe?

Dr. Dan Green: We are trying to take into account you know a lot of feedback that we've received from the – from the – from our stakeholders in the public.

(Pamela Phillips): Yes. And we – and we have submitted comments.

Dr. Dan Green: Well and we – and I'm sure we've received them and, again, we look at all that stuff, but more than that, I obviously can't talk about it because of the rulemaking progress.

(Pamela Phillips): (Sorry).

Barbara Cebuhar: Thanks for your help, (Pamela).

(Pamela Phillips): (Thank you).

Barbara Cebuhar: We have time for one more question and it needs to be a short one, so if you could, (Adam), please?

Operator: And your next question comes from the line of (Louise Dove). Your line's open.

(Louise Dove): Yes, hello?

(Barbara Cebuhar): Yes.

(Louise Dove): OK, I couldn't tell if you got my ding or not. OK, my question is I know that these – all the – this report and all the things we're listening to is going to be available online. Are the questions and answers (inaudible)?

Barbara Cebuhar: I'm sorry; you're breaking up.

(Louise Dove): OK. Are the – are the – is the question and answer section of this Webinar going to be on your printout or when we can get this online?

Barbara Cebuhar: Yes, ma'am. It's available at the PQRS Web site. It will be available, probably in two or three weeks.

(Louise Dove): And the question and answer portion will be in that too?

Barbara Cebuhar: Yes, it will be part of the transcript and the MP3 file. I'm going to tell folks how to get access to the Encore recording, so if people want to listen to it, you can dial …

(Louise Dove): (Yes).

Barbara Cebuhar: … 800-642-1687 and ask for meeting number 44767416 and that'll be available for two business days, until midnight on the – Monday the 18th.

(Louise Dove): OK, but I'm talking about the written that'll be available in two weeks.

Barbara Cebuhar: It'll be available in two weeks.

(Louise Dove): OK. And it'll – it'll have the question and answer section.

Barbara Cebuhar: Yes, it will.

(Louise Dove): OK, great, because my question was answered, but I didn't really hear all the answer, so I'll just wait for reading that and not bother you.

Barbara Cebuhar: Thank you very much.

(Louise Dove): Thank you, hon.

Barbara Cebuhar: I really appreciate everybody's thoughts and participation and questions today. We will be having another special open-door forum May the 26th; from 2:30 to 3:30 Eastern Daylight Time and people can get access to the – to the transcript and the MP3 file in two weeks, by dialing – or by going to the www.cms.gov/pqrs and looking under the sponsored calls section. Thank you very much. (Adam), you can go ahead and tell people to disconnect now. Thank you.

Operator: And this concludes today's conference. You may now disconnect.

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