Centers for Medicare & Medicaid Services
Special Open Door Forum:
2009 Physician Quality Reporting Initiative (PQRI) & Electronic Prescribing (E-Prescribing) Incentive Programs with the American Academy of Orthopaedic Surgeons and the American Association of Orthopaedic Executives

Tuesday, May 19, 2009
3:30pm-5pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will co-host a Special Open Door Forum on the 2009 PQRI and E-Prescribing Incentive Programs with the American Academy of Orthopaedic Surgeons (AAOS) and the American Association of Orthopaedic Executives (AAOE).

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent, but only authorized incentive payments through 2010. Eligible professionals who meet the criteria for satisfactory submission of quality measures data for services furnished during the reporting period, January 1, 2009 - December 31, 2009, will earn an incentive payment of 2.0 percent of their total allowed charges for Physician Fee Schedule (PFS) covered professional services furnished during that same period. The 2009 PQRI consists of 153 quality measures and 7 measures groups.

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes a new and separate incentive program for individual eligible professionals who are successful electronic prescribers (e-Prescribers) as defined by MIPPA. This new incentive is separate from and is in addition to the quality reporting incentive program authorized by Division B of the Tax Relief and Health Care Act of 2006 - Medicare Improvements and Extension Act of 2006 (MIEA-TRHCA) and known as the Physician Quality Reporting Initiative (PQRI).

This Special Open Door Forum will be geared towards orthopaedic-specific topics related to participation in the PQRI and E-Prescribing Incentive Programs. Following the presentation, the telephone lines will be opened to allow participants to ask questions of the AAOS/AAOE presenters, including Robert H. Haralson, III, MD, MBA; Toya M. Sledd, MPH, MBA; Barbara Sack, MHSA, CMPE; as well as CMS PQRI subject matter expert, Sylvia Publ.

PQRI information and educational products are available on the PQRI dedicated web page located at, http://www.cms.hhs.gov/PQRI , on the CMS website. E-Prescribing information and educational products are available on the E-Prescribing dedicated web page located at, http://www.cms.hhs.gov/ERXIncentive , on the CMS website.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 94236628

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

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

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at, http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning May 28, 2009.

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

Thank you for your interest in CMS Open Door Forums.

Audio Link for this Transcript:
http://media.cms.hhs.gov/audio/SpcFrmODFPQRIWITHORTHOSURGEONS.mp3

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Special Open Door Forum: 2009 Physician Quality Reporting Initiative (PQRI) & Electronic Prescribing (E-Prescribing) Incentive Programs with the American Academy of Orthopaedic Surgeons and the American Association of Orthopaedic Executives

Moderator: Natalie Highsmith
Tuesday, May 19, 2009
3:30pm-5pm ET

Operator: Good afternoon. My name is (Abigail) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare & Medicaid Services Special Open Door Forum on the 2009 Physician Quality Reporting Initiative and Electronic Prescribing Incentive Program with the American Academy of Orthopaedic Surgeons and the American Association of Orthopaedic Executives.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Abigail) and good day to everyone and thank you for joining us for this special Open Door Forum on the 2009 PQRI and E-prescribing Initiative Program with AAOS and AAOE.

Today this Special Open Door is geared towards orthopaedic specific topics related to participation in the PQRI and e-prescribing incentive

programs that are authorized by the Medicare Improvements for Patients and Providers Act of 2008 also known as MIPPA.

Our presenters for today include Dr. Robert Haralson III, Toya Sledd, Barbara Sack and our CMS PQRI subject matter expert, Sylvia Publ. PQRI information and educational products are available on our PQRI Web page at www.cms.hhs.gov/pqri . E-Prescribing information and educational products are located on our e-prescribing web page at www.cms.hhs.gov/erxincentive .

I will now turn the call over to our American Academy of Orthopaedic Surgeons presenters, Toya Sledd and Dr. (Haralson).

Toya Sledd: Thank you, Natalie and good afternoon everyone. I'd like to start off by giving an overview of the electronic prescribing incentive program and then go over some of the benefits and challenges to adopting e-prescribing systems and participating in the program.

Now, by definition, e-prescribing is the transmission using electronic media of prescription or prescription related information between a prescriber, dispenser, pharmacy benefit manager or health plan either directly or through an intermediary including an e-prescribing network.

E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. Now the incentive program is a separate incentive program that Congress passed with the MIPPA legislation in July of 2008.

The program was implemented January 1 of this year and participation in the program is voluntary. In order to participate, an eligible

professional must have a qualified e-prescribing system; have at least 10% of the Medicare Part B covered services.

Those must be made up of codes that appear in the denominator of the e-prescribing measure, which Dr. Haralson will mention later, and the eligible professional must report on one of the three G codes at least 50% of the time on Medicare Part B claims.

Now because the program is separate, one could earn an additional 2% for reporting in PQRI. And excuse me for being tongue tied, my brain is kind of frazzled today.

Claims must be reported no later than February of 2010. And that's February 28, 2010 for reporting the e-prescribing measure in 2009.

Now I'd like to talk about some of the benefits and challenges for adopting e-prescribing and participating in the program. Now some of the benefits of e-prescribing include eliminating illegible handwriting, adding checks and alerts for harmful drug interactions, an up to date medication list and streamlining the process such as refill request.

And it will also increase practice efficiency and it improves patient compliance and convenience. And then also, I'd like to add that e-prescribing it enables a more informed choice of therapy for your patients.

Now there are many challenges that some of you may have faced. And one of the biggest challenges is choosing the appropriate hardware and software and then implementing it into your practice, whether it's an EHR system with e-prescribing functionalities or a standalone e-prescribing system, the financial costs can vary.

Factors that drive the costs includes customizing a system that meets your practice needs, interfacing it with your current practice management systems as well as physician staff training and maintenance and upgrades of the system that you have in your practice. Also adjusting to the change in practice workflow can be a challenge, presenting a steep learning curve for your physicians and staff.

Now in the specialty of orthopaedics, as some of you or all of you may know, a large percentage of our prescriptions are for controlled substances. And because the DEA currently prohibits electronic transmission of prescriptions for controlled substances, this has created a major barrier for those who are interested in adopting and using e-prescribing.

Another major challenge is the connectivity with pharmacies, and that includes mail order pharmacies, because some of these pharmacies are not electronically connected. So it is very important that when you're looking into your vendor software and what have you, you want to make sure that your pharmacies in your area are equipped to handle e-prescriptions.

Now for the e-prescribing incentive payments, the payment is calculated based on allowed charges for all Part B covered services furnished between January 1, 2009 through December 31, 2009.

Labs and Part B drugs that are not priced on the physician fee schedule are excluded from the calculation.

Now for 2009 and 2010, those who successfully e-prescribe can receive a 2% bonus of their total Medicare payments for the year. And

then in 2011 and 2012, the incentive amount is reduced to 1%. And then in 2013, the amount is further reduced to 0.5%.

And then I would like to add because I've gotten many calls from our orthopaedic surgeons and orthopaedic executives of how the incentive payments will be paid out.

Now the incentive payments will be paid to the holder of the tax payer ID number and these payments will be issued sometime mid 2010.

Now if you have a copy of our presentation today, if you look at Slide 8, this slide, it represents a hypothetical scenario. Now if your net Medicare revenue earned is $300,000, you could potentially earn $6,000 for reporting, for e-prescribing. Now that does not include the additional 2% incentive payment or the $6,000 you could earn if you participate if you participate in PQRI.

So now I'd like to turn it over to Dr. (Haralson) to go over in more detail how you can participate, determine whether or not you meet the 10% threshold and what's considered a qualified e-prescribing system as well as go over some of the helpful scenarios that will help you envision the e-prescribing process. Dr. Haralson.

Robert Haralson: Thank you, Toya. If you'll turn to Slide 9, first of all, how can you participate? No registration is required, you just start doing it. But you do have to have a qualified e-prescribing system and we'll talk to you in a few minutes about what a qualified e-prescribing system is.

As Toya said, you have to do at least - 10% of the total Medicare Part B payments have to come from the list of the office based codes, that is the denominator codes and we'll talk to you a little more about that.

You need to report on at least 50% of the eligible patients. And if you start now or in July, you still have to hit 50% of your patients and so if you start in July for the most part, you have to do 100% of your patients from then on.

If you go to Slide 10, what is a qualified e-prescribing system? There are a number of requirements. First of all it needs to generate a complete and active medication list. It needs to allow a physician to select medications and print prescriptions and transmit prescriptions electronically. Faxing the prescriptions does not qualify. They have to be transcribed electronically.

It needs to provide information on a lower cost and therapeutic alternatives if they're available. It needs to provide information on formulary medications, patient eligibility and authorization requirements also, if available.

And it must comply with all Part D specifications and we'll show you at the end where you might find out exactly what those Part D specifications are.

On Slide 11 is a list of denominator codes. There are 18 codes here, 15 of which for the most part apply to orthopaedic surgeons. The first five are the 99201 series and that is codes for initial patient visit. Then there's a 99211 series, which is codes for return visits. And then the consultation codes, there are five codes of those.

So those are the denominator codes. There are three other codes for screening and diabetic training, but I think we would mostly use those first 15 codes.

If you turn to Slide 12, these are the three G codes that you'd use in the numerator. These are the three codes that you put on your HCFA 1500 form and I'm going to show you how to do that in a moment.

The first one is G8443, these are all - this is in a situation where all the prescriptions created during the encounter are generated using a qualified e-prescribing system.

G8445 is no prescriptions were generated during the encounter, but the eligible professional has access to a qualified e-prescribing system. And we'll go over some scenarios that demonstrate these in a moment.

G8446 would be some or all of the prescriptions generated during the encounter were printed or phoned in because of state or federal law or regulation or patient request or because the pharmacy system was unable to receive electronic transmission or because the physician prescribed a narcotic or other controlled substance.

As Toya pointed out, the DEA does not allow e-prescribing of narcotics and so if you prescribed a narcotic, this would be the code that you use.

If you turn to Slide 13, this is a way to determine if you qualify, that is you meet the 10% threshold. You take the charges from the codes in the 18 - or the 15 codes that we use, the charges are generated by those 15 codes divided by the total Medicare Part B allowed charges that you submit times 100 and that has to equal at least 10%.

So in the example, if you had $186,663 of charges that were generated by the 15 E&M codes divided by the total allowed charges, $797,705,

times 100, in this situation, it would be 23.4%. So this physician would qualify by meeting the 10% threshold.

Slide 14 suggests again, that the DEA has authority through the Controlled Substances Act over e-prescribing and right now they do not allow it. I think that will change very shortly because as you know, the government is pushing for e-prescribing and so I suspect they'll change that in the not too distant future.

But if you generate prescriptions for narcotics, you can still report using the G8446.

Slide 15 is the first of three slides that describes a scenario. The first scenario would be a 66 year old male who went to the physician for some office medical care and the physician used 99213, which is an intermediate episode for a return patient. Had swelling in his left knee, they discussed current medications and e-prescribed an anti-inflammatory medication. So the physician reported G8443.

Slide 16 is a second scenario. And this is a 28 year old male who presented for office medical care again. Again, this was a new patient and so the physician used 99203, intermediate initial patient encounter. The patient had a sprained right wrist, no fractures. The doctor advised the patient to put ice on the wrist and take Tylenol and he generated no prescription. So the physician would use G8445 in this situation.

Slide 17 is the third scenario, a 51 year old female again for office medical care and the physician used 99214, which is a return patient. Complained of persistent pain and inflammation in the left hip and the physician e-prescribed an anti-inflammatory medication and provided a written prescription at the request of the patient for a pain medication,

for a narcotic. In this situation the physician would use G8446 to report that situation, that is some or all of the prescriptions were generated by the e-prescribing, but the physician did have access to the e-prescribing.

If you turn to Slide 18, you will see how you should report this. The first line of the HCFA 1500 form you would use 99203 or some other of the denominator codes, the E&M encounter codes. And then on the second line you would use the G code, one of the three G codes and that would suffice.

Let me give you a little bit of advice about how we do this in my office and that is I would add those three G codes to the super bill. So, as the physician marked the E&M visit level, the physician would also mark one of those three G codes. And then the transcribers can place that in your computerized billing system.

If you turn to Slide 19, this shows what happens if you don't do this. And this is some advice for e-prescribing as well as the PQRI which Sylvia is going to talk about next.

This is a chance for you to learn how to do this without being penalized for making mistakes. And what we've proven with the PQRI of 2007 is many physicians, even though they tried, they were not successful. And so it’s a little more difficult because of the technology, a little more difficult to do this than it seems at first.

So this is a chance for you to try to learn how to report all of the data without being penalized if you mess it up.

Starting in 2012, you will be penalized financially, for in 2012, they will begin to deduct 1% from your Medicare billings. And in 2013 it's 1.5% and after 2014 it's 2%. So you'll be penalized after 2012 if you don't participate in e-prescribing.

And I don't think it would be too much longer where you may be penalized if you don't participate in some sort of quality measure reporting such as PQRI. I think PQRI will change but I don't think there's much doubt that we're going to eventually be penalized for not participating in quality reporting.

Slide 20 is a list of available resources. I would suggest that the first one, aaos.org and it's the Research Committee Evidence Quality Initiatives. And you'll get some very good advice on how to participate in e-prescribing. And if you do aaos.org/pqri you'll get some very detailed instructions about how to participate in the PQRI.

Slide 21 gives some important contacts. You have Toya's email address there and she'll be glad to talk to you. She should be the first person you should contact, but if you can't find her you can certainly call me. And Barbara Sack's email is on there and she's going to tell us about her experience with PQRI in one of these presentations and so she'll be glad to talk to you.

And now we'd like to turn it over to Sylvia Publ from CMS who is going to talk more about PQRI, but mostly about - some about PQRI, but mostly about PQRI, but some about e-prescribing. Sylvia go ahead.

Sylvia Publ: Good afternoon everyone. Thanks, Dr. Haralson. In this afternoon's presentation, starting on Slide 3, if you've downloaded the slides, we're going to go over what is value based purchasing at CMS and

how PQRI fits in there. What are the measures and codes that are involved in the reporting of PQRI measures, how to implement PQRI and we'll also touch a little additional information about e-prescribing incentives, although Dr. Haralson and Toya Sledd did a nice job of covering that topic. And then lastly some resources that you can use to help you.

Going on to Slide 4, value based purchasing or pay for performance, you see in this diagram an arrow that leads us towards value based purchasing or pay for performance at CMS. You'll see on this slide how in 2007 when PQRI began, how it started with 74 measures and was only a claims based reporting program.

In 2008, through legislation, we expanded the number of measures to 119 measures and we now begin to see that not only can you report through claims, but you can also report through a registry. And you have the new type of reporting; you don't have to just report individual measures, you can report on measures groups and in 2008 there were four measures groups.

Going on to 2009, with the MIPPA legislation, we expanded again to 153 measures now. They can be reported through claims or through registry and the measures groups available now are seven, which can also be reported either through claims or through registries. And we will be doing some electronic health record reporting testing for specific ten measures in PQRI. And then we see the e-prescribing incentive program that we just talked about.

And for 2010, we will be issuing proposed rules for 2010 PQRI and e-prescribing and those will be published through our normal rule making process. In the spring, as you know, we propose the rules and

receive comments and then in the fall we finalize the rules and then implement the following January.

So what is VBP? VBP, value based purchasing, reflects policy concerns about the sustainability of the cost increases in healthcare. Again, uneven quality of care on just the probably high rates of medical errors that we've seen for beneficiaries. Historically, Medicare reimburses for services as long as the claims are submitted appropriately and according to administrative and policy regulations.

This is regardless of the quality of services. And also regardless of whether those services were appropriate to the patient or whether they lead to improved outcomes.

Fee for service, prospective payment is based on resource consumption, not improved outcomes and provides neither incentives nor support to improve the quality of care.

As you know, Medicare is the largest purchaser of healthcare in the world. We have 44 million beneficiaries, which are expected to grow as the population ages. In addition to the expected growth, we have concerns about the sustainability of the program. In the past 30 years, Medicare spending has risen an average of 9.3% annually, which is considerably higher than the gross domestic product of 6.5% per year. Today, CMS spends about $1 billion per day in Medicare alone.

Some concerns about quality have been expressed over the years. The Institute of Medicine has published the Crossing for Quality Chasm among other publications that came out in 2001 through 2006. These reports highlighted the significant gaps in what we know is good care and what actually gets delivered.

We know that beneficiaries do not always receive the care they need from healthcare professionals- we know this from a body of literature that there are tremendous opportunities to improve the quality of care and to improve the geographic variation of that care. So policy makers are asking the question, are tax payers getting good value for the dollars we are spending in healthcare today?

Going on to Slide 5, this is a depiction of the PQRI claims based process. Starting in the upper left hand corner, we see that a visit is documented in the medical record, the encounter form or super bill is documented and quality data codes that can be entered on that super bill, if you like, are then captured in the coding and billing for the claims submission process to the Medicare carrier.

A critical step here of course is that the carrier will receive these codes, these quality data codes and will return back to the provider a remittance advice notice that has the message N365.

For those of you who are new to PQRI, the N365 denial code, denies payment because there is no payment associated with these measures. But the N365 message also denotes to you that your quality data code was passed on to the National Claims History File where our contractor will pick up that data and use it for PQRI analysis.

So again, quality data code line items on your claim will be denied for payment, which is appropriate, but then the carrier does pass that information through to the claims processing system for PQRI analysis.

The N365 code does not denote whether the quality data code is accurate or not. It merely confirms that you submitted a zero line item charge on the bill and that we have processed it as a zero line item.

The analysis contractor then will pick up all of the claims data for PQRI analysis. They will issue a confidential feedback report that's available through a secure web site and then an incentive payment file is generated for approval by CMS and the carrier (MAC) actually processes that payment, incentive payment through a separate check at the conclusion of the program year to the provider.

So this is a simplified diagram of how that data flows from the encounter all the way through the payment of the incentive if the eligible professional meets the minimum of at least 80% of their cases are reported accurately for PQRI for a program year for three measures if three measures apply.

Going on to Slide 6, this slide gives you some additional resources that are available as downloadable documents. From the measures and codes page on the PQRI Web site, there is a 2009 PQRI Measures List, which lists the - identifies the measurer developer and the reporting method. We have the measure specifications for reporting through claims.

These are the 2009 PQRI Measure Specifications Manual for claims and Registry Reporting and the Release Notes. Release notes are important because they describe the changes from the prior program year.

We also have a 2009 PQRI Implementation Guide. This guide walks you through claims based reporting of measures and has some

important reporting principles that apply to claims based reporting of measures.

For reporting measures groups, we do have a separate specifications manual. Measures groups are a compilation of four or more related measures that form a group. In order to group these measures, the denominator specifications need to change in order to fit into one cohesive measures group. So the specifications for measures groups are different than those available for individual measure reporting.

And again, we have a small implementation guide that walks you through how to get started in the reporting of measures groups.

All of that is available again on the Measures and Codes page of the PQRI web site.

Moving on to Slide 7, additional resources that are available to you, for those of you who are interested in registry based reporting, we have a list of qualified registries that are on the Reporting page - Reporting section of the PQRI web site and we have a number of educational resources. On the Educational Resources section of the web site you'll have find MLN Matters articles, fact sheets and tips sheets.

And for those who are interested in reporting one time per patient, per physician there is a 2009 PQRI Patient Level Measures List. This is a subset of the 2009 PQRI Measures List. These are measures that only require reporting on a one time basis per physician, per reporting period.

On Slide 9, I did allude to the claims based reporting principles. These principles apply similarly to the e-prescribing incentive and you will find claims based reporting principles for the e-prescribing incentive program on the e-prescribing web site. But both are similar in content.

The one thing that you need to know is that you need to use the claim. If you're going to report through claims, you need to use the claim for the service, the CPT 1 service that you are providing. The CPT category 2 codes or G codes that supply the numerator must be reported on the same claim for that beneficiary on the same date of service using the individual physician's national provider identifier on the claim.

You cannot for example, forget to report today and think, oh, tomorrow or next week I will report and submit a claim with just a quality data code on it. All diagnoses reported on the base claim will be included in PQRI analysis. Again, claims may not be resubmitted simply to add or correct QDCs. They would be rejected by the carrier if all they see is a claim with nothing but quality data codes on there.

Again, quality data codes are reported with zero dollars as the line item charge. And again, the submitted charge field cannot be left blank.

Going on to Slide 9, additional reporting principles, again, entire claims with a zero charge will be rejected by the carrier and those will not count toward PQRI reporting.

We alluded to the remittance advice notice. Some of you call these the EOB. The carrier will deny the line items with a quality data code on them, but pass them on through the claims processing system.

You will receive a remittance advice notice that has a denial or standard remark code N365. That N365, it's important to check for those on a regular basis to make sure that the carrier is receiving your quality data codes and passing them on.

Going on to Slide 10, we have a 1500 claim example. This example is also available through that downloadable document, the 2009 PQRI Implementation Guide. In this particular example, we see that the patient is seen for an office visit, 99213 and the provider is reporting several measures related to diabetes, coronary artery disease and urinary incontinence.

As you can see, Measure number 2 has a quality data code of 3048F, 3048F has a diagnosis of 250.00 that's related to it on the diagnosis pointer field. Measure number 3, blood pressure in diabetes is 3074F and 3078F, there are two quality data codes associated with that particular measure. Again, that is listed on this claim form.

You also will see on this claim form that the national provider identifier is reported in the rendering provider ID field for group billing. For those who are solo practitioners, in box 33A, the solo practitioner NPI is reflected there.

Well pretty much this 1500 claims sample is self explanatory. We circled the important items on there that you should be paying attention to when reporting on your claims.

Going onto Slide 11, how to get started? We frequently get the question, I've read about PQRI and I've been on the web site, but I don't know how to get started. The first place to get started is to gather the information from the web site and also from other sources. AAOS

certainly has some resources for you and the AMA has also developed some worksheets that you can use for the reporting of measures and the understanding of them.

Determine which PQRI reporting option best fits the practice. Are you going to report through claims, are you going to report three measures or more or are you going to report through a registry?

Again, determine which PQRI reporting period best fits the practice. Some folks have decided to report beginning in January, this past January, and will be reporting throughout the year. Others may not have started yet. It is not too late to get started with PQRI. We do have a reporting period that begins on July 1 and you can use measures groups reporting at any time in the year for a 30-consecutive-patient-sample. We will be talking about the measures groups tomorrow at the National Provider Call.

Going on to Slide 12, consider your practice characteristics. Are there clinical conditions that you are usually treating? Are there types of care that you typically provide? What are your quality improvement goals for 2009? Review the list of measures, determine which measures you want to report and which ones most frequently apply to your practice. Again, you can use the Patient Level Measures List for some of this or just use the entire list.

Review the 2009 PQRI Measures Specifications Manual. It is really important to use the specifications manual to learn how to report and how to code these measures. Some folks have used other sources that may have had incorrect coding on them and so have had those claims not count toward PQRI. It is important to use the authoritative sources

that are posted on the PQRI web site so that you can understand how to report and which codes to use.

On Slide 13, review and study the measure specifications and understand them carefully. It is important to know that the specifications manual is not just a list of codes, but it contains instructions for how to code and how frequently to report a measure.

Some measures, as some of you might know, are reported one time per patient per year but there are others that are reported each time a procedure, surgical procedure is preformed, for example with the perioperative care measures. Each time a surgical procedure is used you need to report on both particular measures.

Select a reporting method either through claims or registry. We do have in the 2009 PQRI Implementation Guide a participation decision tree. It's an appendix in that guide that helps you decide whether to report through claims or through registry and whether you can use a measures group or an individual - three individual measures to report.

On Slide 14, we have found that practices that take the time up front to assemble an implementation team involving both front office and back office staff, that involve the billing software vendor or clearinghouse vendor are better situated in reporting of PQRI measures.

Ensure that you discuss the measures that you want to report with them. Particularly with the vendors, make sure that the vendors can report and have all the information already calibrated in their systems for reporting PQRI for you.

Also, talk with your team, make sure that they understand the measures that are to be reported, that they can identify the fee for service patients that make a case eligible for the measures you have decided to report on.

What is an eligible case? Those are the cases for whom either the diagnosis and CPT procedure on the claim, that combination or if it's a measure that only has surgical procedures in the denominator and no diagnosis, that each time a surgical procedure is performed that is listed in the denominator that claim has been flagged for PQRI reporting.

In some cases the vendors may be able to put in a modification in their system for you - or an edit- so that a combination of diagnosis with CPT 1 service procedures will trigger the question: should you report PQRI? And you have a better bet of catching all of your identified cases.

Again, reading and discussing how to report these measures with your staff is important. Going on to Slide 15, develop a process for concurrent data collection so that you are identifying all eligible claims for PQRI and that the quality data codes are correctly submitted to the carrier.

Also at the other end, once you have submitted the claim, make sure that you review your remittance advice notice or EOBs, so that you do receive and are checking that you'll receive the N365 denial code on your notices from the carrier.

A little bit about the 2007 PQRI Report on Slide 16, we have found that in 2007 a number of issues impacted 2007. Over 12% of cases

were missing an individual NPI for example. Almost 19% had the incorrect CPT 1 listed on the claim for the measure that was attempted to be reported.

We had an incorrect diagnosis code rate of 14%, meaning that the diagnosis did not match the diagnosis - the diagnosis on the claim did not match the diagnosis for that particular measure. And in 7.24% both the HCPCS or CPT 1 service code and the diagnosis code did not match what was being reported on the quality data code for the measure.

And about 5%, all line items on a claim were quality data codes only. And we found that this was due to a number of split claims. Occasionally the carrier will receive a split claim from a clearinghouse or your billing software splits the claim meaning that the payable services are all placed on one claim and the quality data codes are placed on another. CMS is aware of that and we have instituted a process for joining claims when they are truly split prior to arriving at the Medicare carrier system.

Again, from this list, you will notice that a number of claims that were submitted were submitted for cases which were not eligible for the measure because there was a denominator mismatch.

Going on to Slide 17, we spoke a little bit about the split claim problems. A diagnosis pointer issue was another issue that affected some of the claims in 2007. The diagnosis pointer is a field on the claim that relates the line item to the diagnosis on the base claim. And in 2007, PQRI analysis was limited to the content of that diagnosis pointer field, which resulted in a lot of - a number of mismatches.

We have since changed that analytic and so going forward from 2007, which we are rerunning later this year the diagnosis pointer will no longer be a limiting factor. We will use all diagnoses on the claims for PQRI analysis.

And so therefore later this year in the fall, in November, a re-run of the 2007 PQRI data will have been completed by then and we will inform those eligible professionals who qualify in '07 of their incentive.

We also received a number of cases missing the NPI. The NPI does need to be on the claim in the rendering provider ID field and we had a number that did not include the NPI. The claim was actually paid using a legacy number and so a claim without an NPI on it will not count toward PQRI. Unfortunately there is no fix for a missing NPI on a claim so it is important that you ensure that you do have the NPI on all your claims.

We've also had claims that came in that were denied for coverage. A claim that is denied is not counted toward PQRI. We had claims where simply the quality data code was not on the claim at all, and yet was a claim that included either the diagnosis or CPT 1 service procedure for which we would have expected a quality data code.

A number of reasons for that, some folks did not realize that “incident to” billing does affect PQRI, so if you have nurse practitioners that are doing “incident to” billing, they need to be captured; those claims need to be captured for PQRI reporting.

Also nursing home patients, or home health patients also need to be captured on the claim for the measure that you are attempting to report. So again, it’s important, as Dr. Haralson mentioned before that you

understand the denominator of the measure. What is the population that you are reporting on? It is not simply limited to just office visitation. So you need to look at that carefully.

We also had a number of “shared codes” in 2007. These were shared code issues meaning that the CPT II code was shared equally between two different types of measures. And for 2008 we did change those to G codes to address the problem of shared codes on a claim.

Going on to Slide 18, we see a number of - this is an aggregate quality data code error report. We have posted this on the web site; you have the URL on the slide. The quality data code error report tells us of all of the submissions of claims that we’re getting, what percent are valid. And you will see for orthopaedics, we've pulled out some for osteoporosis here, for Measure number 24, communication with a physician post fracture, we have only 51.18% of those are validly being reported.

A valid report means that a claim came in with the quality data code on the claim and the diagnosis on that claim as well as the CPT 1 service on the claim matched the denominator for reporting that particular measure.

Screening for osteoporosis, we have 81.48%, so that’s pretty high. Just about everyone is meeting that particular measure’s reporting requirement. Measure number 40, management following fracture, this would be a hip fracture; only 1.53% are being submitted as valid.

It appears that there are some problems with eligible providers recognizing when to report Measure number 40. And I think they’re related to also measure number 24 in that these are measures that

require more than one quality data code and do have that period of post fracture that needs to be captured- that could be challenging to report through claims.

Measure 41, pharmacologic therapy for osteoporosis, 43.92% of all claims are coming in as validly reported. Again, in those cases, it's possible that not all of the eligible claims are being identified by eligible providers.

Going on to Slide 19, we see a number of measures here, these are all related to perioperative care measures, timing of prophylactic antibiotic for Measure 20, the selection of the prophylactic antibiotic for 21, the discontinuation of the antibiotic and VTE prophylaxis.

And out of that, the first measure, Measure number 20 is the one that jumps out as only 13.42% of all claims are being submitted as valid, meaning that there's a lot of reporting going on there that for a number of surgical procedures, which may not necessarily meet the denominator coding for that particular measure.

On Slide 20, some of the common errors that we do see on the claims that are coming in, by far and away across all claims, we are seeing that providers are having difficulty identifying eligible cases. And so there are a number of claims that missed reporting of quality data codes when that claim was actually eligible for reporting the quality data code.

Reporting of a quality data code on a claim for a diagnosis that was not listed in the denominator of the measure, reporting of a quality date codes on a claim with an office visit code but the measure required reporting either for only a surgical procedure code or only a

consultation code. So there’s some over reporting and some under reporting that is going on.

Over-reporting typically does not hurt you, but it’s under-reporting that will. When reporting the quality data code for a measure, ensure that your staff is identifying all eligible cases.

Reporting one quality data code on a claim when the claim requires two quality data codes or reporting a diagnosis on a claim when two diagnoses should be reported. Again, another aspect is reporting a quality data code with a CPT 1 modifier. And we see this is in spurts and just recently we've had a number of claims that have been called to our attention that providers are using the wrong modifier.

As some of you may know, CPT Category II codes have specific modifiers, 1P, 2P and 3P. Those are the only modifiers that can be used on a CPT Category II code. And we are seeing that some folks are putting in CPT 1 modifiers.

If you put the modifier on the wrong code, it will delay your claim and it will certainly be denied and so we’re asking for folks to remember that modifiers are important, you need to use them correctly, both in PQRI and on your claims in general.

Reporting a quality data code on a claim for a service that was not covered by Medicare, in other words, the payment for that claim was denied. And as we mentioned before, denied claims will not be considered for PQRI incentives.

Lastly, the individual rendering NPI wasn't listed on the claim and we've talked about that before that that needs to be on the claim for it to be considered for PQRI.

Going on to Slide 21, some of the benefits of participation were alluded to by Toya Sledd and Dr. Haralson. This is a time in PQRI's evolution that you can participate in quality reporting and not necessarily have any kind of penalty associated with the reporting of the quality data. You will receive a confidential feedback report to support quality improvement efforts.

That confidential feedback report is available to you through a secure web site at the conclusion of the program. We do not have an ongoing feedback mechanism other than the N365 denial remark code that you will see on your remittance advice.

You have an opportunity to earn a bonus incentive payment for PQRI participation and an opportunity to invest in the future of the practice by preparing for higher bonuses, preparing for when we do come in to a pay-for-performance environment. We continue to and remain on a pay-for-reporting environment at this point. And this allows you to prepare for the public reporting of performance results.

On Slide 22, you have a depiction of the CMS PQRI web site. There is a left hand navigation bar that gives you all of the section pages on this web site starting with the overview page that gives you an overview of PQRI, a Spotlight page that will give you information. Go to that Spotlight page - where we post new items on the PQRI web site, we will spotlight them on that page.

I've circled here the Measures/Codes section and the Educational Resources section where you will find information that will help you implement PQRI.

On Slide 23, we have a number of frequently asked questions that are posted with answers on the PQRI Web site. By searching using keywords, you can find answers to a lot of questions that you might have.

Lastly, there's a physician listserv that you can sign up to receive updates on PQRI as they are posted and certain announcements about the National Provider Calls that we hold monthly and the Special Open Door Forums such as this one that we have held.

And now on Slide 24, we'll begin to talk a little bit about the e-prescribing incentive program. If you do not have a qualified e-prescribing system in place, you cannot participate in this measure; you do have to have a qualified system implemented.

On Slide 25, this is another diagram similar to PQRI that depicts how the data flows from a particular encounter. E-prescribing is an encounter-based program, in other words for those eligible encounters you would be reporting the G code for e-prescribing. And the goal here is obviously to set up a three-way triangular communication between the provider, the pharmacy benefit manager and the pharmacy so that all three are on the same page with respect to that particular patient's medication list of current active medication.

Again, when the e-prescribing system generates a transmittal to the pharmacy, it should be captured on your encounter code, submitted to coding and billing staff who would then submit the G code that's

relevant to the carrier/MAC. The carrier/MAC will then respond back just as we saw before with PQRI, an N365 denial code will go back to the staff confirming that the carrier - well, the MAC received the e-prescribing G code and has sent it on to the National Claims History File where it will be analyzed by the contractor.

Again, after the conclusion of the year, there will be a confidential feedback report that will be posted on a secure web site. This is the only time where you would need to register in the CMS IACS system to receive a password and a user ID that you can then use on this secure web site to obtain your feedback report. A payment file would then be issued to the carrier/MAC to pay out the incentives for a successful e-prescriber. So that's the depiction that you see on this slide.

Going on to Slide 26, what is not e-prescribing? It's important to understand that some things do count for e-prescribing and some do not. If you call in a prescription, you are not e-prescribing. E-prescribing is predicated on the fact that you've had a face-to-face encounter claim that you will be seeking reimbursement for.

A patient seen in the emergency department is sent home with a written prescription. Emergency department visits are not included in the denominator for the measure of the code and you'll notice that home health and nursing home patients are also not included on that denominator.

The pharmacy - the physician generated a fax that was sent to the receiving pharmacy. If you are generating a fax you are not e-prescribing, you need to send a specific e-prescribing transmittal, simply sending a fax to a pharmacy does not count for e-prescribing.

Sending a prescription via a PDA, if the PDA meets all of the e-prescribing system qualifications, it will count for e-prescribing. But if it does not, that does not count. Knowingly sending a computer generated fax initiated at the doctor's office to a pharmacy, the only exception to that rule is when it is sent through a qualified e-prescribing system.

In many cases, there are pharmacies that cannot accept your e-prescribing transmittal and the pharmacy will actually convert your message to a fax. And so therefore that would count as e-prescribing.

Office visits during a global surgical period that result in a prescription will not be counted as e-prescribing. Also Medicare Advantage patients, although you can certainly e-prescribe for any Medicare Advantage patient, do not put the G codes on Medicare Advantage claims because they will not count toward e-prescribing and could in fact delay the claims processing at that health plan.

Going on to Slide 27, just wanted to talk a little bit more about the use of G8446, meaning that you have an e-prescribing system in place but you could not use it for specific reasons. And these are the only specific reasons: that you are prescribing a controlled substance or that you are prohibited from prescribing due to state or federal law or the patient asks for a hard copy or the pharmacy cannot receive the e-prescription transmittal, such as a mail order pharmacy for example. So the G8446 can be used under those circumstances only.

Again, just wanted to remind you that there are claims based reporting principles that apply to the e-prescribing program and you should use

those, be aware of those principles when you are submitting the G codes on your claims for e-prescribing.

Again, CMS does not change specifications to measures mid-year. We stick with the measure such as it's specified on the e-prescribing measure specification listed on the web site. So even if Dr. Haralson did elude that the DEA might allow e-prescribing of a narcotic, our measure specifications will stay the same, so you will need to report accordingly throughout the reporting period.

And on the last slide, I want to thank everyone for your attention and we conclude this talk. And we can now open up the question and answer session.

If you do come across a question that we have not responded to during this presentation, you can certainly submit it through the PQRI mailbox that is posted on this last slide. And again, thank you everyone.

Natalie Highsmith: Okay, just want to check to make sure the American Association of Orthopedic Executives didn't have anything further to present on the topic today.

Barbara Sack: Actually, I do have...

Robert Haralson: Barbara, go ahead.

Barbara Sack: I do have a little bit to add. I do not have a handout. I would prefer that everybody be kind of visualizing your own processes and your own practices for what I have to say.

But just to give you some practical tips and observations about participation in both the PQRI program and the e-prescribing program, we have been doing the PQRI program in this practice since 2007 and did successfully report and get paid for it. And we have continued to participate and we are now doing e-prescribing.

The things that I would want to tell you about PQRI, just to kind of get things boiled down to the simplest terms possible for an orthopaedic practice. After looking at all of the information that I gathered in preparation for starting the process, I found that everything you need to do in order to qualify for payment, you are almost certainly already doing. What you need is a process to document it.

And what I mean is that according to the AAOS information that I looked over, there were 12 measures that applied to orthopedics. Four of them were surgical measures; the others were all office based measures.

All of the office based measures were for things that were perhaps a good thing to do, but not something that my physicians routinely did, such as screening for fall risks, screening for osteoporosis, medication reconciliation, those kinds of things.

We all can agree that those are good things to do but they were not things that my physicians were routinely doing already. And I felt strongly that any time you are trying to implement a process or procedure and there is payment at the end of it, if you are successful, that's not the time to try to also do something new.

The program as has been noted several times is a pay for reporting program. And I would venture to guess that most, if not all orthopaedic

surgeons are already doing their best to perform with best practices, do things the right way and in fact you probably are already doing what you would need to do in order to successfully participate.

So if you take for example, the measures that were on Slide 19 in the CMS handout, I believe it's Slide 19, the perioperative measures, numbers 20 through 23, if you have standing orders for all of those things and if you go back and look up each of these measures, it will define them for you. You probably have standing orders that correlate with all of those four measures.

If you do and actually whether or not the procedure goes according to your standing orders, as long as you report what happened, then you will qualify. What we did was put together a form, which is in the library on the AAOE web site that had those four measures and then a listing of all of the general orthopaedic procedures to which they apply.

That was put together by using both CMS worksheets and AAOS worksheets. The AAOS did a fabulous job of putting together a ton of information to tell you which procedures would you have to report an additional G code on.

And so by putting together a worksheet that said, here's your four measures, they all correspond to some of your standing orders. If you do one of these CPT procedures and it went according to your standing orders, check the box in the appropriate places. If it didn't go according to standing orders, you use your modifier to say why not and then submit them.

What you need as much as anything, is to have a process in place to make sure that that happens. And that will happen in your billing

office, your back office, with your surgery scheduler, preparing sheets when they identify a Medicare patient, getting that sheet to the physician who then hands it in to the billing folks once he has performed the procedure and filled in the necessary information.

And then the billing folks will be looking to see if I am inputting a Medicare surgery that includes one of these codes, do I have an additional G code to report because as you heard, it cannot be done afterwards. So the process was the important thing. Once we got all of that in place, it was fairly seamless and painless. And it went just fine for us.

On the electronic prescribing, what I would just tell you is that you probably don't - if you are doing it already, you probably would want to start with just the threshold required to participate. That will get you started on the road, but will not plunge you into the deep end where you feel like you're treading water and why did I ever start this.

Because the controlled substances are prohibited from being transmitted electronically and some mail order prescriptions cannot be transmitted electronically, the number of prescriptions that you actually submit electronically is astoundingly low.

For orthopaedic physicians, they can probably count on one hand the number of different prescriptions that they write and half of those are probably narcotics and cannot go electronically. A certain number more will be for medications that patient prefers to have in - on paper for a mail order pharmacy or if they're traveling, for whatever reason, the number that you actually have to submit is astoundingly low for orthopaedic.

So if you start with that in mind and with the idea that you are going to try to hit the threshold to participate, which is basically 50% of your Medicare E&M visit. So half of your Medicare E&M visits of which you will only have a written - have a prescription e-prescribed, a medication prescribed for a certain number.

For the visits in which there is no medication prescribed, there is a G code for that. For the visits in which there's a medication prescribed but it's on paper, there's a G code for that. And then for those few others that can be submitted electronically, there's a G code for that.

And there are ways to implement that with a low number - a low amount of stress and cost. We actually are using a standalone product that is free of charge as we look at what kind of EMR to implement and how we might incorporate that then into an EMR.

So from the perspective of an orthopaedic administrator, I would just say that you need to make it as simple as possible, especially for the providers who are probably already doing things that they need to do in order to qualify. All you have to do is then document it and submit it.

And if you have a claim-scrubber software, write an edit for it so that the system will not submit those Medicare claims with those specific CPT codes on them unless there is an additional G code on it.

We were able to write edits for our claim-scrubber system that said for example, if this payer type is Medicare, the financial class is Medicare and there is an E&M visit, then where is your G code?

So that allows you prior to submitting, to ensure that you have the additional code on there. And the other thing to remember there is that you cannot submit it - although it says to submit it with a zero charge, most practice management systems will not allow you a line item with a zero charge, a zero dollar charge.

And our practice management system, we have told to round up all charges to the nearest dollar. So even if we put in 1 cent, it will round it up to a dollar and then once that line item is denied, you have to then write off that amount, which is not a big deal.

But you do have to, for most practice management systems, have some amount in that line. So that would be very quick, practical tips and observations from participating in both programs. And with that, I think that we are now ready for questions and answers.

Natalie Highsmith: Okay, thank you everyone. Now Abigail, we're ready to move in to our open Q&A portion of the call. If you can just remind everyone on to how to get into the queue to ask their question.

And everyone, please remember when it is your turn, to restate your name, what state you are calling from and what provider or organization you are representing today.

Operator: At this time, I would like to remind everyone if you would like to ask a question, simply press star 1 on your telephone keypad. To withdraw your question, press the pound key. Your first question comes from the line of Alison Kuley in Connecticut. Your line is open.

Alison Kuley: I actually have a couple of questions. The first one is, where are the slides from the first part of this presentation because they were not

included with the package that we just went through and I couldn't find them anywhere on the web site.

Natalie Highsmith: They are on the American Academy of Orthopedic Surgeons web site. They are there if you scroll down, you'll see in the middle of the page, it'll have the third link under the What's New section. In the middle of the page, you'll see the link that says AAOS and AAOE Co-Sponsors Open Door Forum. You click on that link. You scroll down to the bottom and you'll see two links of presentations, one for AAOS and AAOE and the other link for CMS.

Alison Kuley: Great. Okay, the other question was if you were doing e-prescribing and PQRI, would those be two separate 2% bonuses?

Robert Haralson: The answer to that is yes. You would get 4% if you do both of them.

Alison Kuley: It would be? Okay, so the last question and then I'll let you go, is the physician generated fax, our system, we do prescribe electronically and what it does is it sends the fax to the pharmacy right through our computer. Is that not a qualifying system? I'm not understanding that part of it.

Barbara Sack: That is not a qualifying system.

Alison Kuley: Okay.

Sylvia Publ: According to CMS, faxes are not qualified because it does not then automatically offer you alternatives and give you things like contraindications, other medications that are prescribed and so forth. So for all of those reasons, although it is an electronic delivery of the information, it does not qualify as a qualified e-prescribing system.

Alison Kuley: So our system would have to be linked with the pharmacy system?

Barbara Sack: That’s correct.

Sylvia Publ: You should be able to link not only with a pharmacy system but with a pharmacy benefit manager. What you’re trying to do is set up that three-way communication electronically between the three entities. And a computer generated fax does not do that.

Alison Kuley: Right.

Sylvia Publ: You’re basically just imaging a prescription at one point in time and sending it to the pharmacy and that is not e-prescribing.

Alison Kuley: Great, okay. Thank you very much.

Operator: Your next question comes from the line of Maggie Mondello in Missouri. Your line is open.

Maggie Mondello: Hi, my name is Maggie Mondello. I'm calling from St. Louis, Missouri. I'm calling from the office of Dr. James Walentynowicz at Chesterfield Orthopedics.

My question is and I do not currently participate in either program. So this question may be silly. But it’s easy to see that it wouldn't take very much recording to maximize the diagnosis fields on a specific HCFA. So how do you then report all of the various diagnosis codes with relation to one or two or three procedures?

For instance if you do three specific procedures all at one time and they themselves carry multiple diagnosis codes, how then do you work in the diagnosis codes that would qualify for PQRI?

Robert Haralson: From an orthopaedic standpoint, the diagnosis is not particularly important except if you use the four codes, 20 through 24, the three antibiotic codes and the strong antibiotic prophylaxis codes, those are all tied to a procedure, not to a diagnosis.

So for instance, if you've done a total hip or total knee, it could be for rheumatoid arthritis or osteoarthritis or any of the other arcidities, but the reporting code, the PQRI code is tied to the procedure, not to the diagnosis.

Now, if you get on aaos.org web site slash PQRI, you can download a worksheet, just one page long that lists those four reporting codes, those four G codes and all of the applicable CPT codes that go along with it.

And if your physicians have routine order sheet, as was already pointed out, if your physician has a routine order sheet, you’re paid for reporting, not for doing. So if your physician has a routine order sheet that includes those three antibiotic codes, that is starting out before surgery, use of first-generation Cephalosporin and stop it within 24 hours. And then a thromboembolic prophylaxis, if they have routine order sheets, then all you’ve got to do is tell your coder every time I do one of these eligible CPT codes, you put these four G codes down. And then you’re through.

Maggie Mondello: Okay, so you've never run into a situation where we did more than four diagnosis codes on a HCFA.

Robert Haralson: You don't need any diagnosis codes for this. Obviously you need to get paid but you don't need a diagnosis code if...

Maggie Mondello: Okay, I'm getting it now. So we can all relate to again, if you did a total knee and you used OA of the knee, you can just then all relate those G codes to that 71516, correct?

Robert Haralson: You need to relate the G code to a diagnosis. The G codes, they don't go to - you don't have to put a diagnosis for them.

Maggie Mondello: You can send it without a pointer?

Robert Haralson: That’s my understanding. Sylvia?

Sylvia Publ: No, you need to relate the quality-data code line item to a specific diagnosis, whatever that diagnosis is for the procedures you are already billing.

Maggie Mondello: Okay, okay.

Sylvia Publ: For the surgical procedure, that’s the diagnosis you’re going to relate it to.

Robert Haralson: So if you’re doing a total joint for instance or you’re doing a...

Sylvia Publ: Right or a total hip for example and the diagnosis is hip fracture, go ahead and put the hip - you know, you can relate that on the diagnosis pointer to the hip fracture.

Maggie Mondello: Okay, thank you very much. I understand.

Sylvia Publ: Yes, the diagnosis pointer field cannot be left blank.

Robert Haralson: Okay.

Operator: Your next question comes from the line of Jennifer Petrella in Florida. Your line is open.

Jennifer Petrella: Hi. I was just wondering, just to make sure, the whole group doesn't have to do it, if only one of my physicians in the group wants to do it, that still makes them eligible, is that correct?

Robert Haralson: That physician is eligible because you're going to be reporting by the NPI.

Jennifer Petrella: Yes, just the individual NPI.

Robert Haralson: The check's going to come to the pay number, so then your group has to decide how you're going to split up the reimbursement among the physicians. But so it's reported by NPI but paid by pay number.

Jennifer Petrella: Okay, just (unintelligible) so basically if one of my guys is doing it and the - obviously if one of them is doing it and then it comes back to the tax ID number, it's all his or however they decide to work it out.

Robert Haralson: If I were him or her, I would insist that it's mine.

Jennifer Petrella: Yes, well sure, sure. I understand. And the other question I was curious about was on the claim reporting, the zero dollar charge, if the system doesn't allow a zero dollar, I just want to make sure that I can put $1 in and that's going to be fine, not a problem?

Robert Haralson: Yes.

Barbara Sack: That's what we've done. And I would also tell you that if you go further and get your feedback report from the web site, it will tell you by NPI who participated, who did not, who was successful and who was not and how much of the amount sent was applied to each physician. So for...

Jennifer Petrella: (Unintelligible) you said the next reporting period begins July 1, at least for PQRI. I understood the e-scribing was a year thing and obviously at this point, we need to be a 100% and that was clear in the presentation.

But for the July reporting period, what percentage do we need to hit for PQRI if I'm equating it to the e-scribing situation? You know what I mean? Is it 50%? What do we have to do for this reporting period to make sure that we qualify? Is it all CPT codes from July 2009 until what makes us eligible?

Barbara Sack: I actually had a similar question. I think Sylvia's the one who could answer that. Sylvia, if we are - another practice has asked me if they want to participate in PQRI starting July 1, the PQRI threshold is 80%, the ERX threshold is 50%, can you enter either of those programs July 1 and just simply start reporting on July 1 and still hit the same threshold? Or will it be 50% for the year for ERX and then similarly for PQRI, what's the threshold if you start July 1?

Sylvia Publ: The only option of starting July 1 relates to PQRI, not to e-prescribing. There is no July 1 start date for e-prescribing. It started January 1 and goes through December 31.

Robert Haralson: So the answer is you could start now for e-prescribing but you need to hit 100% of your patients from now on to be able...

Jennifer Petrella: We got that completely, that's easy.

((Crosstalk))

Jennifer Petrella: But I'm more concerned about the PQRI. If I start July 1, 80% needs to be done by what, December 31, 2009 and what does that make me eligible for, 2% of the claims from July 1 until December 31?

Sylvia Publ: For PQRI, the only option of starting mid-year after July 1 is to use a measures group and there is a perioperative care measures group. Within that measures group, you have two options for reporting, a 30 consecutive patient sample or an 80% patient sample.

Jennifer Petrella: Or 80%, okay for the measure group, that's the only option I have to start July 1?

Sylvia Publ: Right.

Jennifer Petrella: And then I would be eligible...

Sylvia Publ: When you're reporting a measures group...

Jennifer Petrella: ...that timeframe, obviously.

((Crosstalk))

Sylvia Publ: Yes.

Jennifer Petrella: Okay.

Sylvia Publ: When you're reporting a measures group, you do need to report on all of the measures in that measures group that apply to that patient.

Sylvia Publ: And there is a measure group...

Jennifer Petrella: On 30 consecutive patients in that measures group, okay.

Sylvia Publ: Yes, and there is a measures group for perioperative care measures.

Jennifer Petrella: Perioperative care. Okay and I'll be eligible for 2% on all of my Medicare allowables from...

Sylvia Publ: You would be eligible - if you start July 1 for a measures group, the way you begin is by indicating - telling us through the claims system that you are starting a measures group. There's an intent code, a G code that tells us that is the date you're beginning.

Jennifer Petrella: Got it.

Sylvia Publ: Okay and from that date forward, depending on what you do, either you do a 30 patient sample for a 2% incentive or you do 80% of all your applicable cases during July 1-December 31 for a 1% incentive. And for most surgeons, it's probably going to be the 80%.

Jennifer Petrella: Okay. And if I had a physician do that intent code in January or somewhere in there in the first half of this calendar year, he'd redo it starting again for the next - July, like another 30 - or another 30

consecutive patients or another 80%, I'm not sure really how he’s doing it, you know?

Sylvia Publ: Unfortunately, once you start a measures group, you can't repeat that measures group.

Jennifer Petrella: Like once he’s done that 80 - then does he...

Sylvia Publ: You told us in January you were starting...

Jennifer Petrella: Yes.

Sylvia Publ: ...we would have expected reporting after that date. And if we didn't receive it on any of your claims, then...

Jennifer Petrella: I would have expected (unintelligible) N365.

Sylvia Publ: Pardon me?

Jennifer Petrella: Is that what you mean? Where I would have gotten a report now, some other sort of report, sorry.

Robert Harrelson: Sylvia, her other question was, when you calculate the reimbursement, if you started July 1 and let’s say you did either, the measures group or the 80%, starting July 1, that amount you will be paid would be 2% of your Medicare billings from July 1, it wouldn't be the whole year, would it?

Sylvia Publ: It will not be the whole year. It will only be a half year incentive.

Robert Haralson: That’s what I...

Jennifer Petrella: Does it always operate in half year incentives? I guess that's more of my question. If my physician did a measures group starting in January, and let's say he did 30 consecutive patients, and now he's done 30 consecutive patients. Does that make him - is he done for the whole year? Is he done - does he get 2% of all of his Medicare allowables for the whole year or does he only get the half a year and he can't start over? And you're saying no he can't?

Sylvia Publ: Let's go back there. The 30% consecutive patient sample...

Jennifer Petrella: For the 30 consecutive, yes.

Sylvia Publ: It has to be consecutive by date of service. You can use that sampling methodology and you can start it at any time of the year through the reporting period for a full year incentive.

Jennifer Petrella: For a full year incentive. But then that goes against what you just said about July. You said if I started in July when the other gentleman asked a question, you said no, he would only be eligible for Medicare allowable from July 1.

Natalie Highsmith: This is Natalie. I think that this is a question that we need to take offline, plus we have to move on to our other participants in the queue who have to ask questions. Jennifer, can you send your inquiry to pqri_inquiry@cms.hhs.gov ?

Sylvia Publ: One last comment, there is a decision tree that describes all of the options to what portion of the incentive they apply to. That decision tree is on the 2009 PQRI Implementation Guide. That will guide you as to what is applicable for full year versus a half a year.

But if you sent your intent to report G code in January, it would be our expectation that as of that date in January, you would have reported on your claims for at least 30 consecutive patients by date of service and you would be done by now.

Operator: Your next question comes from the line of Deborah Snyder of South Carolina. Your line is open.

Audrey: This is Audrey and I'm at Greenville Hospital System. We are implementing our e-prescribe and I have just a question about the qualified e-prescribing system. Of the criteria that you list, one of those was that you should be able offer patients a lower cost medication and for the program that we use, that will be coming in that program later on.

But I think that I read and I just want to confirm that for 2009, you do not have to have that piece of the criteria in place, right?

Robert Haralson: Sylvia?

Sylvia Publ: I'm sorry; could you repeat that question again?

Audrey: For the list of criteria that you have for e-prescribing, the qualified systems, one of those qualifications was for you to be able to offer a lower cost medication or therapy. And for our system that we use, that will be coming in the future but is not in there right now. But I thought that I read for 2009 that that was not a requirement. Is that correct?

Sylvia Publ: The requirement is "if available" - that's not one of the core requirements for the qualified e-prescribing system.

Audrey: Okay. But then it said in the - what I had read, it said for 2010 it would be required, is that correct?

Sylvia Publ: That is correct.

Audrey: Okay. So if we do it now, the other criteria are important, but just that one is not?

Sylvia Publ: That is correct.

Audrey: Okay, thank you.

Operator: Your next question comes from the line of Gretchen Feldman in Florida. Your line is open.

Gretchen Feldman: Hi. I'm with Tampa Orthopedic Clinic, a physician practice of two physicians and one PA in Tampa, Florida. My question is I would like to know how I can communicate with the appropriate office to understand my report for the 2007 PQRI reporting that I did.

We had received a check of a minimal amount and I did access the report, but I had many questions once I accessed the report to determine what we did wrong. So who can I talk to about this?

Sylvia Publ: Can you give me your phone number?

Gretchen Feldman: Yes, it’s area code 813-977-4767.

Sylvia Publ: Thank you.

Gretchen Feldman: And will someone...

Sylvia Publ: (Unintelligible).

Gretchen Feldman: All right. Thank you so much.

Sylvia Publ: We will contact you.

Gretchen Feldman: All right. Thank you.

Operator: There are no further questions in queue at this time.

Natalie Highsmith: Okay, well I guess we can go ahead and end the call now. Sylvia or Dr. Haralson or Barbara, did you have any closing remarks.

Robert Haralson: Yes, I thank everybody for participating and feel free to get in touch with Toya Sledd or me. And I know we've invited some non-orthopaedists and we'd be glad to answer your questions too. And we look forward to talking to you.

Barbara Sack: And I would just like for you to repeat if you would, Sylvia the email address to submit questions.

Sylvia Publ: Happy to. That email address is on the last slide of the CMS slides, it’s pqri_inquiry@cms.hhs.gov .

Barbara Sack: Thank you.

Sylvia Publ: Thank you all very much.

Natalie Highsmith: Thank you all again. Abigail, can you tell us how many people joined us on the phone line?

Operator: The high point, we had 208.

Natalie Highsmith: Ok, 208, wonderful. Thank you, everyone.

Sylvia Publ: Thank you.

Operator: This concludes your conference call for today. You may now disconnect.

END