Centers for Medicare & Medicaid Services

Special Open Door Forum:

2009 Physician Quality Reporting Initiative (PQRI) Program with the American College of Emergency Physicians (ACEP)/CEP America

Thursday, November 12, 2009

2:00-3:30 pm ET Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will co-host a Special Open Door Forum on the 2009 PQRI Program with the American College of Emergency Physicians/CEP America. 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.

This Special Open Door Forum will be geared towards emergency medicine-specific topics related to participation in the PQRI Program. Following the presentation, the telephone lines will be opened to allow participants to ask questions of the ACEP/CEP America presenters, including: Dennis Beck, MD FACEP; Richards Newell, MD MPH; and Mike Granovsky, MD FACEP, as well as CMS PQRI subject matter experts.

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.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 31712023

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 and transcript 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 November 23, 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 files for this transcript: http://media.cms.hhs.gov/audio/PQRIwACEP111209_Pt1.mp3 & http://media.cms.hhs.gov/audio/PQRIwACEP111209_Pt2.mp3

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Special Open Door Forum:

2009 Physicians Quality Reporting Initiative Program

with the American College of Emergency Physicians (ACEP)/CEP America

Moderator: Natalie Highsmith

November 12, 2009

2:00 pm ET

Operator: Good afternoon. My name is Mason and I'll be your conference facilitator today. At this time I would like to welcome everyone to the Center for Medicare and Medicaid Services Special Open Door Forum 2009 Physicians Quality Reporting Initiative Program.

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 that time, simply press star and 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, Mason, and good day everyone and thank you for joining us for this Special Open Door Forum on the 2009 Physicians Quality Reporting Initiative Program co hosted with the American College of Emergency Physicians.

Today this Special Open Door is geared toward emergency medicine specific topic related to participation in the PQRI Program. I would now turn the call over to Dr. Dan Green for opening remarks.

Dan Green: Thank you, Natalie. Welcome, everyone. Thank you for joining today's call on 2009 PQRI. We're privileged to be co-hosted today by the American College of Emergency Physicians. And I thank you all, in advance, for your comments and your insight into PQRI.

We have three speakers today from ACEP. Dr. Newell is a Board Certified Emergency Medicine physician. He received his Medical Doctorate degree from the University of Buffalo, School of Medicine Biomedical Sciences, and his MPH from Harvard University.

Dr. Newell completed his residency training in emergency medicine at Harvard UCLA Medical Center. After residency, Dr. Newell completed an Emergency Medicine Administrative Fellowship with CEP America.

Currently Dr. Newell is practicing Emergency Medical Physician at CEP America Hospital in San Jose, California and will be Medical Director January 1. He is CEP America's CMS Program Coordinator, overseeing organizational hospital quality measure PQRI HCAHPS, and POA HAC performance, also known as Hospital PQRI conditions.

Also joining Dr. Newell today is Dr. Michael Granovsky. Dr. Granovsky is a Board Certified actively practicing emergency physician. He's the President at MRSI and ED Coding and Billing Company.

Dr. Granovsky is the Education Chair of National ACEP's Coding and Nomenclature Advisory Committee, and of course Director of ACEP's National Coding and Reimbursement courses. He is a Certified Coder and served as a subject matter expert for the American Academy of Professional Coders Emergency Department Subspecialty Certification. He is also the Editor of Emergency Department Coding Alert

Joining Doctors Newell and Granovsky also is Dr. Dennis Beck, who is a Board Certified Emergency physician and a Fellow of the American College of Emergency Physicians. Dr. Beck has practiced Emergency Medicine for the past 30 years and has served as Medical Director for several Emergency Departments and practice groups. He is the Past Chair of the ACEP Reimbursement Committee and currently chairs ACEP's Quality and Performance Committee.

He also serves on the ACEP Reimbursement Committee, Coding and Nomenclature Committee as well as the AMA Relative Value Update Committee, and has served as Co-chair of ACEP Value-Based Emergency Care Task Force. Currently Dr. Beck is President and CEO of Beacon Medical Services.

Doctors, thank you all for joining us and agreeing to co-host this call. I'll now turn it over to Dr. Newell.

Richard Newell: Thank you, Dr. Green. It is our pleasure with CEP America and ACEP to be co-hosting this Open Door Forum with CMS. I'm going to review the slide numbers as we progress so that everyone can follow along.

I'd ask everyone to review the disclaimers on slide number 2, and we'll move on to the outline for today's Open Door Forum. I'm going to ask Dr. Beck to review the reasons why the PQRI Program was developed, some of the legislative background around the PQRI Program, how the measures are created, and then some of the ACEP activities around the Emergency Medicine measures.

I'm then going to talk about the importance of these measures, who are the eligible professionals, some of the differences between PQRI and core measures, requirements for successful PQRI Program, and use our program as an example for others to build on.

Then I'm going to turn it over to Dr. Granovsky to review the 2009 ED relevant feature PQRI measures, coding and submission of these measures, the 2007 PQRI experience along with feedback report, some of the current and future challenges; and then I will finish up with reviewing some of the references that you will have available to you at the end of your slide packet, and then we'll open it up for question and answer.

Slide 4 is just so you have it in writing, some written information about who your presenters are today. Dr. Beck, I'm going to turn it over to you to start with Value-Based Purchasing in the PQRI Program.

Dennis Beck: Thanks, Rick. I'm going to be fairly brief. My goal is to provide you with a little bit of an overview as to Value-Based Purchasing in the genesis of PQRI and where emergency medicine fits in.

Time precludes a full discussion of value-based purchasing but it's pretty clear that it's a key CMS objective going forward and at the core of value-based purchasing is payment policy that links the quality, efficiency and effectiveness.

I think that it's important to recognize that value-based purchasing includes many strategies such as quality of care, medical home care coordination and performance measures are a component of value-based purchasing.

I'd encourage, on this slide there's a link to the value-based purchasing CMS position paper. It's very worthwhile for emergency physicians and other health care policy folks to review this. I think it's a good summary.

Performance measures as an element of value-based purchasing are intended to create the appropriate payment incentives to encourage providers to deliver a high quality care at lower cost, which is really kind of a fundamental element of value-based purchasing.

Now we go to the next slide, this gives you a little bit of a legislative background for PQRI and without kind of making everybody history experts on PQRI suffice to say that it began in 2007 as a transition from the PVRP, the Physicians Voluntary Reporting Program.

In the second six months of 2007 there were 74 measures and there was a 1.5% incentive payment for reporting. We had several acts since then with the most recent being MIPPA -- the Medicare Improvement for Patients and Providers Act in 2009 -- that has made PQRI permanent, although only funded through 2010, has increased the PQRI bonus to 2% and through some of the other legislative activity has expanded not only the reporting periods, you can report for either 6 months or a year, but also criteria as far as developing measures groups and registry reporting, which we're going to get into in a little more detail later in the call.

The next slide is simply a visual on the transition from 2007 to 2010. Now if you go to slide 8, my goal here was to try to get people to understand that measures aren't really developed by a bureaucrat in a dark room somewhere to antagonize physicians.

Measures are developed to fairly rigorous processes by organizations that have been established to develop those measures. For example, the PCPI or Physicians Consortium for Performance Improvement is an AMA sponsored committee that is the lead entity in the development of quality measures for physicians.

There are over 100 national and state societies, including ACEP that are represented at the PCPI and the PCPI is responsible for a majority of PQRI measures. What drives selection of a measure or an area?

Generally it’s something that’s going to be either high impact with a gap as far as variation in care and with an adequate evidence base behind it. Now to go back to the original emergency medicine measures that we’re going to talk about today, there was a technical expert panel that was convened.

ACEP was well-represented. I was actually on that initial panel. And we developed the measures that we'll be talking about today. Now those measures, whether they’re developed by emergency physicians or other clinical experts, come out of PCPI and then need to be endorsed by an organization. A consensus organization such as the National Quality Forum.

The National Quality Forum has endorsed those measures and then CMS has the opportunity, based on their goals and priorities, to select which measures will become part of PQRI.

The important point is that several steps along the way, for PCPI, the PCPI level, the NQF level, and again at the CMS level, there are opportunities for public comments.

So as a practicing physician, consumers or painters, an opportunity is provided for folks to comment and influence the development of the measures.

Going to slide 9, the purpose of this slide is to demonstrate ACEP’s long-standing commitment to quality and patients safety. The slide demonstrates some of our achievements over the years and I think that the most important one is that in 2005, our board, the ACEP Board of Directors ,has put together a committee. The Quality and Performance Committee and that committee have been very active in terms of development of measures and commenting on measures that have been developed by other organizations.

Let’s move on to slide 10. Slide 10 demonstrates the role that ACEP played as far as co-chairing the PCPI Emergency Medicine Workgroup with the resulting measures that, as I said, we’re going to go into a little greater detail on today. I think that the important point here is that these were measures that represented frequent presentations to emergency departments that represented conditions that would be seen by virtually 100% of practicing emergency physicians. Perhaps just as important that these measures are from an (ITD&I) and CPT and G-code perspective are reasonably simplistic as far as data abstraction.

The next slide, slide 11, shows the measures that at this point have been endorsed by the National Quality Forum as one of their initiatives. National Quality Forum is evaluating hospital-based emergency care and is part of Phase 2. Again, ACEP was very involved as far as co-chairing this workgroup. We developed the following measure that's articulated on slide 11. Now at this point these are NQF endorsed measures, some of which may go on to PCPI.

Some may go on to be core measures when you look at some the measured in there. There may be better candidates to go to core measures, but there are a number of clinician-specific measures in here as well.

The two measures that were submitted was developed actually through the Quality Committee approved by the ACEP Board, and then went on to NQF were the pregnancy tests for female abdominal pain patients and anticoagulation for acute pulmonary embolism. So with that, I will turn things back over to Dr. Newell for the rest of the presentation.

Richard Newell: `Thank you, Dr. Beck. We're on slide 12 and I'd like to review why PQRI measures are important. As Dr. Beck mentioned, they are a measure of quality. It's very difficult for us to link short term care intimately with long term outcomes, so we need surrogate measures and these are an example of them.

As mentioned, there are foundations in evidence-based medicine. They are developed by professionals and designed to improve the quality of care. They are a way that an emergency department group can follow quality.

In fact, they can review their performance at QA and QI meetings as a way to improve the quality of care. From the hospital perspective, there's a way that the hospital leadership can see the ED group as delivering quality of care and as far as credentialing, they actually fit very nicely with the new requirements for OPPE or Ongoing Professional Practice Evaluation.

There are financial implications with the PQRI measures. They are a cost control method as Dr. Beck mentioned in transitioning to value-based purchasing.

There are rewards with financial incentive for reporting. Reporting is the first step towards a true pay-for-performance. They do set up a framework for

other payers to transition to a Pay-for-Performance and they also enhance public accountability on the level of the provider.

Slide 13- Eligible Emergency Professionals include emergency physicians, nurse practitioners, and physician assistants.

Slide 14 compares and contrasts core and PQRI measures differences. I find this very helpful as most of us as providers know the core measures intimately. However, we're also trying to get up to speed on the PQRI measures.

So the first difference is; Who is accountable for the performance? For core measures at the hospital? For PQRI measures it is the provider? Who reports the performance? For core measures it is the hospital? For PQRI measures it is the billing company? The last difference I'd like to highlight is what patients are included in the measures? For core measures, they're all admitted patients regardless of payer. For PQRI measures they're both admitted and discharged Medicare Part B patients.

Of course, as I preach to our group, we can't really be looking at payer status when we're delivering care so we need to be delivering top quality PQRI care for all of our patients.

Slide 15- I'd like to take the next two slides to review some of the requirements for a successful PQRI Program. If you're still in the midst of setting up a program, the first requirement is the organization's priority must be quality care.

Quality must permeate throughout the entire organization from the Board of Directors, to senior leadership, to regional directors, to site medical directors and to providers.

There needs to be a willingness on the part of the organization to invest both time and money on quality to make it a successful PQRI Program. There needs to be collaboration with the billing company and an ability to efficiently and effectively collect, organize and report data.

Slide 16 lists three more requirements for a successful PQRI Program. There needs to be a dedicated person overseeing the program development and performance. This person needs to have the ability to communicate with the

organization’s leadership in addition to the providers, and have some ability to also interact within the organization.

There needs to be an ability to rapidly and effectively educate providers. An ability to provide timely feedback to both providers and directors which allows for quality improvement.

Slide 17- I'd like to use our organization as an example of a PQRI Program that others may be able to build upon. To give some background, we are the largest democratic emergency group. We began caring for patients in the early '70s, and now we provide care for 3 million emergency department patients a year.

We started our program in 2007. We had up front collaboration with partnership, leadership and our billing company, Med-America Billing Services. We developed and organized vision for the PQRI Program. My position was created as CMS Program Coordinator, where I oversee PQRI performances in addition to other CMS quality programs such as the core measures.

I'm available for questions, trouble-shooting and giving presentations. Provider education is key. There must be constant updated web-based education, which we do. There are in-person presentations at our partnership meetings, regional meetings and also our mid-level provider meetings.

We have developed some supplemental practice material that may be placed in the department to assist providers in real time.

Slide 18 shows an example of this. This lists the current measures report on and how the providers can document adequately performances to meet these measures.

Slide 19- We have Performance Reports and Semi-annual Reports on the organizational, regional, and site levels. This allows for the appropriate directors to be able to take responsibility for performance and performance improvement.

The program coordinator discusses the performance with the medical directors at the site and discusses possible PQRI performance improvements. If we

have time, we provide feedback to the providers and you're going to see this on Slide 20 and 21.

This allows for the individual providers to actually see how they're performing and to allow quality improvement. Some department PI projects may be able to be designed around PQRI performance and this may fulfill the administrative requirement for recertification.

Slide 20 gives an example of a feedback report that we generate to provide to our hospital site, the emergency department director. As you can see from this, this is reporting on the four pneumonia measures.

On this slide, if you have the slides printed off in color, it's very easy to review the performance. The red represents being not appropriately documented or performed, and the green represents being appropriately documented or performed.

If you move on to Slide 21, this is a provider-specific report. On the left-hand column, you'll see provider A, B and C. Obviously we would have physician names or provider names in there. You could actually review how your performance is based on quarter.

Slide 22 is when I'm going to turn it over to Dr. Granovsky. This is really how the nuts and bolts of where to start with a PQRI Program, the CMS's web page. You'll see on the left-hand column there we've circled Measures and Codes.

Dr. Granovsky, I'm going to let you go from here to review the 2009 ED relevant PQRI measures, coding and submission of these measures, the 2007 PQRI experience and feedback reports, and then discuss some current and future challenges before we open it up for questions and answers. Dr. Granovsky?

Michael Granovsky: Dr. Newell, thank you very much and we will get down in the lead starting on Slide 23. For 2009 there are 153 PQRI measures, and there are specifically 10 that are most relevant to Emergency Medicine.

On Slide 24 you'll see the initial seven: aspirin at arrival for AMI; EKG for non-traumatic chest pain; EKG for syncope; and then the four pneumonia measures: vital signs for community acquired pneumonia; assessment of

oxygen saturation; assessment of mental status; and pragmatic antibiotic therapy.

On Slide 25, we see some additional ED potential measures. Measure number 8, listed on (prior) 25; prevention of catheter-related infection, and this is interesting in construct because as opposed to an ICD-9 trigger, this is one of the measures that's relevant to emergency medicine that actually has a procedure trigger, the CPT procedural code as an example, 36556 triggers the requirement for the PQRI reporting.

So then two stroke measures, which do not cross walk to the 9928x code, but instead cross walk to critical care code. So our potential ED measures, patients receiving DVT prophylaxis, which is not clinically common in the emergency department, and then consideration of thrombolytics in stroke.

That measure, which we will speak about in greater detail, is being reformatted, probably when the newer set of specifications are being released. Look at the individual measures in detail, starting on slide 26.

Measure number 28, aspirin in AMI. Percentage of patients, regardless of age, within a ED diagnosis of AMI who had documentation of receiving aspirin within 24 hours before ED arrival or during the ED stay.

And if the clinician is not going to provide aspirin therapy, they should document why. You can see that this measure tracks to the 9928x code, then the diagnosis triggers are also there, the four ten point acts of (QDMI) ICD-9 family.

There's your number 31, again, the parenthetical. This is not a common clinical practice in the ED but is a potential measure since it does cross walk the 99291.

Acute ischemic stroke patients who there is a recommendation clinically to provide prophylactic low dose subcu Heparin or low molecular weight Heparin or acute ICH recommending the initial use of intermittent pneumatic compression since obviously these patients would not be receiving chemical anticoagulation.

Measure number 34 was commented on in the Medicare Physicians C Schedule Proposed Rule as being analytically challenging and in the final rule,

which came out just this past week, will likely be reformatted, so we won't spend a lot of time on it.

So then two measures related to cardiovascular testing, EKG in chest pain, measure number 54, which you can see on slide number 29. The percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain that had a 12-lead EKG performed.

Again, the note, if not going to obtain an EKG, document the medical or patient reason for not doing so. You can see that this measure cross walks to both 9928x and the critical care code as well.

On slide 30, you see the measure here for EKG in syncope. Again, percentage of patients aged 60 years and older with an ED diagnosis of syncope, who had a 12-lead EKG performed.

The applicable E&M Levels are 9928x and the critical care code as well. There's also a single ICD-9 code for syncope that's noted within the specifications, 780.2.

We will now review briefly the four pneumonia measures. Measure number 56, vital signs in community acquired pneumonia. Some of the definitions within the measure: clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the medical record that vital signs were reviewed or some other indication that the vital signs had been reviewed.

Crosswalking to 9928x and 99291. Measure number 57, Oxygenation in Community Acquired Pneumonia, (CAP) seen on slide 32 shows, some of the sub description of the requirements to meet the measure: clinician documentation that oxygen saturation was reviewed, dictation by the clinician, including oxygen saturation; or clinician initials in the chart that oxygen saturation was reviewed.

Measure number 58, as seen on slide number 33 shows, Mental Status in CAP. Medical record may include documentation by the clinician that the patient's mental status was noted, e.g., the patient is oriented or disoriented.

On Slide 34, we've got antibiotic selection in community acquired pneumonia, measure number 59. There are four drug classes identified: Floroquinolones,

Macrolide, Doxycycline, and then a combination therapy of Beta Lactam with the Macrolide or Doxycycline.

Of note prescribed, so meeting the requirement for this measure would include patients who are currently receiving medication as part of the treatment plan that was recommended and had encountered during the reporting period even if the prescription for that medication was ordered prior to the encounter.

Measure number 76, seen on slide 35. This is the Central Venous Catheter Insertion measure (CVC). Cap and mask and sterile gown and sterile gloves and a large sterile sheet as well as hand hygiene and 2% chlorhexidine for cutaneous antisepsis.

Again, if you're not going to use a maximum sterile barrier technique, there could be clinical reasons why, you should simply state that and then we'll talk a little bit later about the modifiers that would be used to describe that.

In this case, you can see at the bottom of slide 35 that a CPT procedural code triggered here, is consistent with most of the central venous access code rather than the more common construct where there's an (ICG&I) diagnosis code serving as the initial trigger.

A little bit of an overview of the measure submission process. Currently emergency medicine relevant PQRI measures are really submitted via claims based mechanism. However, it is possible, in the future, that they could be submitted via an electronic health record or even a registry.

The code reporting period now is January 1, 2009 through December 31, 2009. As noted, the recent release of the Medicare Physicians Final Fee Schedule Rules for 2010 shows a calendar year reporting period for 2010 as well.

Satisfactory reporting would involve reporting on three PQRI measures or more with 80% of the applicable cases successfully reported. And again, this 2010 final rule had similar specifications.

Let's look at PQRI from an operational process. What's going on behind the scenes? The first thing that happens is the cohort population for the individual provider, based on their NPI is identified. And this occurred simply by reviewing the denominators of the measure.

What are the denominators? They are typically the ICD-9 diagnosis code associated with the appropriate 9928x for this central venous access code.

In this example we'll talk about acute MI and use the 104 code family. CMS will then look for the eligible CPT code for the service provided for the patient.

The dual requirement of 9928x and the ICD-9 code for (10 point act) will trigger the PQRI reporting requirement. CMS then requires the physician to report the code for the MI quality measure. In this case 4084F and that's defined as aspirin for acute MI.

You can see on slide 38, a very nice description of the flow of data. The first thing that happened is, it's documentation in the medical record. The encounter form then goes to your coding and billing entity. Then in a critical step, the coding and billing entity transmits the data to your carrier or your MAC, the current CMS Part B claims processor.

That information then goes into the National Claims History File and is ultimately sent on to an analysis contractor. The analysis contractor does two things. They provide a confidential report that ultimately (we'll talk a little bit more about the reporting) goes back to you and they notify the carrier MAC of your reporting status and the MAC then issues an incentive payment.

There's a critical step, and we'll focus on it a little bit more. At the time that you're coding and billing company submits the PQRI code to the carrier, there is an N365 remittance advice that takes place. We'll drill down on that a little bit more.

If we look on slide 39, the Claims-Based Reporting Principle, there are several things to keep in mind. The CPT Category II code or the G-code which supplies the numerator must be reported and there are some specific requirements.

It must be on the same claim for the same beneficiary for the same date of service. All diagnoses reported on the claim will be included in PQRI analysis and the codes must be submitted with a line item charge of zero dollars at the time the associated service is performed.

If your individual billing system does not allow a zero dollar line item, you are allowed to submit a nominal amount of $0.01 cent, but you should not leave that charge field blank. We'll actually look at a representation of a 1500 form. You do not want that charge field blank, because it will not crossover.

Talking a little bit further about this remittance advice N365, to just review, entire claims with a zero charge will be rejected. The total charge for the claim cannot be zero dollars. Physicians will receive Remittance Advice back and it will include what's called the standard remark code N365.

This is the message that confirms that the QDC, the PQRI code, has passed into the National Claims History File. So that's very important. The N365 Remittance Advice lets you know that the PQRI code has passed into the National Claims History File. The wording does not necessarily suggest that, but that is the intent. This procedure code is not payable. It is for reporting/information purposes only.

The N365 remark code does not indicate whether the PQRI code is accurate for that claim or for the measure, but it does tell you again. It gives you an idea on a single case-by-case basis that it has passed into the National Claims History File.

We'll spend a moment looking at an actual 1500 form and going through some of the areas where I've seen this process get off track. First, we need to define some of these fields. In the upper left-hand side you can see field number 21, which is where the qualified PQRI diagnoses may be listed. There can be up to eight (8) diagnosis codes entered electronically.

Field 24D. 24D is your CPT code from the 9928x series, 99291 or your PQRI code. Very importantly, you will then see field 24E. That's the diagnosis pointer field. The diagnosis point field must contain an ICD-9 PQRI trigger.

So when your PQRI code is listed in that CPT column in 24D, right opposite there needs to be a diagnosis pointer that links back to field 21 that includes a PQRI qualified ICD-9 code.

I would say that this is a common way that things get off track. If you look to the upper right-hand side of your slide, a couple of other comments. The PQRI codes must be submitted with a line item charge of $0.00. The charge field cannot be left blank.

On Slide 42, we'll review briefly PQRI scoring. The scores will be reported as a percentage of compliance and there’s a numerator and a denominator. The numerator, the number of patients with the PQRI code or a modifier assigned.

And the denominator, all Medicare patients with the diagnosis, for example, of acute MI and the level of service CPT code noted in the specifications. So there’s both a numerator and a denominator.

Meeting the requirement; The PQRI process translates clinical actions so they can be captured in an administrative claims process. It describes really three (3) possibilities.

The measure requires what’s met or the measure requires what’s not met due to documented allowable performance exclusions. Or the measure requirement was not met and the reason is not documented or is not consistent with an acceptable performance exclusion. And we'll go through these.

If the measure is not met, but the physician group is still committed to reporting fully on PQRI, there are modifiers available and they are encouraged to be used to accurately report the reason why the measure specification was not met.

First possibility is the provider documents appropriate performance of the measure. For example, you've reported on modified Code 4084F as an example related to aspirin for AMI.

What if the quality measure was not achieved? There are several modifiers. They are termed P modifiers: 1P, documentation for medical reasons, 2P, a patient reason, 3P a system reason, and 8P the reason is a little bit unclear, quote, "not otherwise specified."

We'll go through aspirin for AMI as an example. Again, just to refresh aspirin within 24 hours of arrival or during the ED stay. The CBT category to Code 4084F and: 1P, documentation of the medical reason for not receiving aspirin; 2P, documentation of a patient reason for not receiving aspirin; 8P aspirin not received, reason not specified.

We'll go through a couple of vignettes to really further clarify this process. A 73-year-old female presents with an acute MI. The physician documents giving aspirin.

Report 4084F. You're using the unmodified code. A 68-year-old male presents with an acute MI. The physician documents not giving aspirin due to history of anaphylaxis. Report 4084F 1P, with a medical reason.

A 26-year-old male using crack cocaine presents with an acute MI refuses aspirin. 4084F 2P, a patient reason. Eighty-two-year-old (82) male is brought in by EMS with an acute MI. Aspirin is perhaps given by EMS; it's a little bit unclear. You may still report the PQRI Code 4084F, but in this case you would assign 8P, reason not specified.

On slide 47, we have some summary data from the 2007 PQRI Experience report: 12% of submitting cases were missing an NPI; 18%, almost 19%, incorrect HCPCS code; 13% incorrect diagnosis code, 7.24% both incorrect HCPCS code and diagnosis code. And then 4.97%, all line items were QDC only.

You cannot report only the PQRI code. You want to make sure that your PQRI code is listed in that CPT field. You want to diagnosis this is part of the PQRI measure specifications and you want the diagnosis pointer field to connect your PQRI code to your ICD-9 measure specification code. This is very important.

Some PQRI results, in slide 48, shows 2007 claims data. There were 631,110 unique tax ID numbers that could have participated. About 15.74% attempted to participate.

Interestingly, there were certain specialties that were more successful. Emergency medicine was among the top three, which included Emergency Medicine, Ophthalmology and Anesthesia.

The PQRI Economic Experience. What does the PQRI bonus mean? In 2007, a total of $36 million was given out in PQRI bonus. The average individual payment was $600 at 1.5% for six months. Remember that initial reporting period was only for Q3 and Q4 of 2007 and it was at 1.5%, where as for 2009, 2010 were at 2% and a full calendar year.

The average group payment was $4,700. And the largest group payment was $205,700. Opting out for future requirement, 109,000 reported in 2007 and 56,700 met the reporting requirement.

Again, some common errors: eligible claim without the individual NPI; eligible claim but without the actual PQRI code; eligible claim was submitted for only the PQRI code; or it was a totally ineligible claim from that PQRI measure because either the diagnosis , the surgical procedure or the patient's age was incorrect.

Some feedback reports include; Confidential Feedback Reports today. We know that hospital data is public and that the core measure data is very public. Reporting of successful participation, I would go even further by saying may occur, will likely occur in the future.

In the 2009 physician final rule we can see the following quote: "We are contemplating a physician compare Web site for the public reporting of quality data. It is our intent to identify the eligible professionals who satisfactorily submit data on quality measures for 2009 PQRI on the CMS Web site in 2010." This is seen on slide 52.

Again, with the recent release of the 2010 Medicare Physician Fee Schedule Final Rule, these sentence sentiments were further reinforced and do appear to be likely.

Getting your scores: The initial mechanism available to obtain scores, involved registration in what is called the IACS system, Individual Authorized Access to CMS Computer Services.

There are many, many steps involved. The first of which is designating a security office. There's a certain amount on requisite information required. Your TIN legal business name, corporate address, but in particular Internal Revenue service form CP575 in hard copy. A very difficult form to locate for a group that's been in business for some time.

There is an IACS user help desk. The number and the email address are seen at the bottom of slide 53.

Responding to some of the feedback that was received, CMS created a second mechanism for providers to receive information regarding their PQRI scoring and processes. There was a MLN Matters issued during the late summer:

Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative Data and Feedback Reports.

Non IACS score reports discussed in slide 55: CMS now has an alternate mechanism for 2008 PQRI feedback reports. Beginning on October 19, 2009, individual physicians can call their respective carrier and contact center to request 2007 Re-run data, or 2008 PQRI feedback reports that will contain data based on your individual NPI.

When requesting the feedback reports, the typical script will be: “you'll be asked to provide an email address and you can then expect to receive email feedback and a report within 30 days of the request”.

The first step involves contacting your carrier and we've provided some contact list information and the types of questions that the phone process can answer. "Was my incentive payment sent?" "What is my incentive payment amount?"

If you have some Remittance Advice back from CMS where you have specific questions, there is a hotlink at the bottom of slide 56 which will allow you to access the contact information and phone numbers for your individual carrier to ask for a 2008 feedback report.

In the future as we go through the 2009 final rule and the 2010 final rule, it seems clear that over time the claims-based submission process is very arduous on both the provider’s side, the clinician’s side, and on the CMS side as well.

There seems to be a general indication of trying, overtime, to move away from claims-based submission. There will be an expansion of reporting options: claims-based, EHR based, or registry based.

And again, while we propose to retain the claims based reporting mechanism for 2010, we know that we are considering significantly limiting the claims based mechanism. After that, I would say that that seems to be consistent throughout the rule.

The future: The proposed role in 2010 mentioned PQRI measure number 34, stroke and consideration of TPA and described it as analytically challenging.

Again, the recent beliefs of the 2010 final rule describes that this measure would likely be reformatted when the final specifications come out.

CMS has allowed itself some additional time beyond the publication of the 2010 final rule and has indicated that final PQRI specs for 2010 will be available and posted to the CMS PQRI Web site sometime between November 15 and December 31.

Of note, there is for the first time, relative to the emergency department process, a pneumonia measured group. And it's measures 56, 57, 58, 59 that we spoke about earlier in the lecture which are now assimilated and aggregated together in a single measures group.

The final specs will tell us how that group will ultimately be scored, but it's an alternate method for scoring ED PQRI performance and probably again will be reportable within the framework of a measures group.

I'm going to transition now back to Dr. Newell, who will help us wrap things up. Dr. Newell, thank you very much.

Richard Newell: Thanks, Dr. Granovsky. Slides 59 and 60 list some additional resources that may be of assistance to you. Slide 61 lists your co-host today on behalf of CEP America and ACEP.

We're both very pleased to have been able to partner with CMS to open this Open Door Forum to provide some assistance to others going through the same challenges that we are. Our contact information is present on that page. Both of our organizations want this program to succeed and we're both here to provide support if needed, so feel free to contact us.

Slide 62, I'd like to open it up for questions at this time.

Natalie Highsmith: Okay Mason, we do want to pause one second before we move into the Open Q&A and turn the call over to Dr. Michael Rapp who works in our Office of Clinical Standards and Quality.

Michael Rapp: Good afternoon. This is Michael Rapp. I am the Director of the Quality Measurement and Health Assessment group here at CMS. We're providing

leadership for the PQRI program and I just want to emphasize a point that was made about the access to the feedback reports for 2007 Re-runs and for 2008.

We had a great deal of interest from the professionals reporting under PQRI to be able to get their feedback information. Last year the only mechanism we had available was at the group level.

So, some persons that was connected with a group overall would get the report which would contain all of the individuals that were participating in PQRI and then would have that information and they would then need to distribute it to the group members.

But we had a lot of interest from individuals to be able to get that and also we wanted to have an easier, you know, process to get it. So that's why we've established this alternative feedback report mechanism.

So, I want to just emphasize that for every individual, regardless of whether your practice as individuals or practice in small, medium or very large group, you can call up your carrier and you can then get that feedback report yourself.

The feedback report I think, you would find fairly interesting. First of all, it has all the information in terms of what was reported with regard to measures. It talks about the extent that you were successful; how you were successful at those claims-based reporting and registry based reporting.

It also has information on the amount of bonus payment that was calculated for each individual. The bonus payment is a percentage, 1.5%, of the total physician fee schedule allowed charges for that particular individual physician.

So what that means is you would have that information. First of all, how much was billed in your name and, in addition, how much bonus was paid based upon reporting for the services that you rendered.

So, this is, again, available. We have many thousands of participants in PQRI and an individual report was made for each and every one of those individuals.

So, we're hopeful that people will take advantage of this feedback. It's a very important part for a number of reasons, but first on that list would be, of course, this program is about measuring quality.

So many of the issues that we talk about is just the technicality of getting the information in and what kind of requirements there are for qualifying for the bonus itself.

The other information that you will get back is your performance rate and what is the level of quality being measured by these particular measures involved.

We will later be providing a lot more aggregate level information about the 2008 program in terms of success for reporting for all types of measures, but again, and I think a very important aspect of that we will be publishing or posting more information about that.

Just what is the performance rate on the different measures? Many of them are actually quite high as you can probably anticipate, particularly for some of the emergency medicine measures, like getting an EKG for non-traumatic chest pain and so forth.

Others are not so high, but then also we've analyzed these measures from a perspective of beneficiaries. We focused a lot on the eligible professionals and how they participate and so on and so forth. But we, the program fundamentally are about beneficiaries and measuring the quality of care that they are getting.

So I just wanted to encourage you to call your carrier and the individuals and get your feedback report, certainly if you haven't received it, from whatever group that you may practice in. That's all I have.

I –want to congratulate you on an excellent presentation. It's obvious that emergency physicians are very engaged and interested in this program. I am not quite sure what the statistics are, but I think emergency medicine was sort of at the top of the rung last year in 2007. I presume again, this year in terms of participation in the PQRI program. So we thank those parties that have been participating in this Open Door Forum.

And so now I will turn it back to Natalie. We can go for the questions.

Natalie Highsmith: Okay. Mason, if you can just remind everyone on how to enter 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, in order to ask a question press star then number 1 on your telephone key pad. We'll pause for just a moment to compile the Q&A roster. Your first question comes from the line of Marcy Lugo from Florida. Your line is now open.

Marcy Lugo: Yes. Good afternoon. My name is Marcy Lugo and I'm calling from Florida and I represent South Florida ENT. In regards to a recent communication - yes? Yes? Do you hear me?

Natalie Highsmith: Yes, we can hear you.

Marcy Lugo: Okay, great. In - CMS just released on October 30th information on PQRI and the E-prescribing incentives. I have a quick - hello? It's breaking up. Do you hear me correctly?

Natalie Highsmith: We can hear you.

Marcy Lugo: Okay. It states that, first of all, I'd like to know if a provider in 2009 is reporting during the second reporting period, what would be the percentage of incentive that he would receive.

Dan Green: This is Dan Green from CMS. So basically if you're reporting in the second six months, you're talking about, I assume PQRI and not e-prescribing. Is that correct?

Marcy Lugo: No, just - yes, correct. PQRI reporting.

Dan Green: Okay. So if you choose one of the acceptable methods to report for the six month reporting period, for 2009 you would receive 2% of your covered Medicare Part B services for in fact that six month period, so from July and through the end of December.

Marcy Lugo: Okay.

Dan Green: So the incentive is based on the reporting period for which you participate.

Marcy Lugo: So regardless if you participate the entire year or not you're going to receive 2%?

Dan Green: The percentage is the same; it's just whether it's for 6 months or 12 months. Again...

Marcy Lugo: Okay.

Dan Green: …depending on the reporting period.

Marcy Lugo: Okay. Great.

Dan Green: Is there a question about e-prescribing as well?

Marcy Lugo: No, no it's not. It was just for PQRI.

Dan Green: Thanks. I think what you heard was an echo we had on the line so...

Marcy Lugo: Oh, okay. Yes...

Dan Green: Thank you for your question.

Marcy Lugo: You're very welcome.

Operator: Your next question comes from the line of Teresa Bolden from Oklahoma. Your line is now open.

Teresa Bolden: Good morning. This is Teresa Bolden from Oklahoma representing Peck & Associates and what we are, we are a billing service. We have been with this

PQRI Program from the very beginning and I have been on all of your phone calls.

Last year we, I am for our business the Security Officer and we are set up as a surrogate user group, okay. And then for each of our clients that we bill for, they had to register and I asked they have their own security officer and then they want me to access their reports for them. So they designated me as their end-user for the individual physicians.

Now last year I was able to access those reports, analyze them, and help the physicians make sure that everything is appropriate for 2009 reporting. But for some reason now I am no longer able to access those reports. Has there been a change somewhere that I have not received the notification?

Michael Rapp: I guess I'm not quite sure. So I - is your IACS account valid?

Teresa Bolden: When I sign into IACS, I can get in without a problem.

Michael Rapp: Okay.

Teresa Bolden: When I try to sign in to the QualityNet portal, it says that I cannot be authenticated.

Michael Rapp: Okay. Well, then you call the help desk?

Teresa Bolden: I have called the help desk numerous times, received numerous responses and then today, again, I've tried to reach the help desk. I have been on hold three different times for more than an hour, couldn't hold any longer, so I had to hang up.

Michael Rapp: Okay. So why don't you give us your number and we can call you off line?

Teresa Bolden: Okay. My phone number is area Code 405-364-3040.

Michael Rapp: And while we're certainly sorry that you're having difficulty accessing the report though you've got the IACS account. How many doctors do you - you say you're a billing service?

Teresa Bolden: Yes.

Michael Rapp: One thing of course is, as I mentioned, that individual doctors can get them themselves this year, which they weren't able to do last year. So pending resolution of this and we're sorry you're having difficulty, we'll try to figure out what the problem is for you.

Teresa Bolden: Thank you very much. I appreciate that.

Operator: Your next question comes from the line of Christina Martini from New York. Your line is now open.

Christina Martini: Hi this is Christina Martini. I work for Peak Performance Physical Therapy. I have - had a problem submitting claims into Medicare because of my computer system.

It was a technical problem because the claim did not have - the PQRI code not have a value so it was not included on my claims, yet when I view the claims in my system, it showed that they were there. The PQRI codes, I'm talking about.

But it never got transmitted over to the clearinghouse or to Medicare. Is there anything I can do to resubmit it, you know, now that we can have it corrected? In other words, it was like a technical problem.

Dan Green: Yes, unfortunately, we're not able to accept claims for resubmission solely for the purpose of appending a quality data code for PQRI. If your claims were rejected for some other reason...

Christina Martini: No.

Daniel Green: ...certainly again then you would be able to add the code. But in the future...

Christina Martini: But what is a registry?

Michael Rapp: Well, I think one thing is there's a way to, I believe, append a claim. We don't have the billing folks with us, but I think where there - sometimes there's ways of dealing with it that way where there's a technical...

Christina Martini: To do - I'm sorry. Can you repeat that?

Michael Rapp: Have you talked to your carrier about it?

Christina Martini: They're telling me that I can't resubmit, but I also called the help desk through CMS and they told me to get a registry?

Michael Rapp: Yes, a...

Christina Martini: But I really don't understand what that is.

Michael Rapp: Okay. What type of practice does your...

Christina Martini: Physical therapy.

Michael Rapp: Physical therapy. If Dr. Green will explain the registry.

Dan Green: So if you look on our Website under alternative reporting methods, you'll see a list of registries that are qualified for 2009 data submission.

Christina Martini: Yeah, I have a list of them. I just don't understand what they...

Dan Green: Okay. So, also you'll see which measures they intend to report and for what reporting period. So what you might do is for the measures that you'd like to report, find a registry from that list...

Christina Martini: Right.

Dan Green: ...that intends to report those particular measures. Call them up. They'll give you specific instructions. Each registry collects data in a different - well, I shouldn't say in a different way, but there's several ways but, they're different.

Christina Martini: Okay.

Dan Green: So what I would suggest is the registries that are collecting information on the measures you want to report, you should contact each of them and you can find out how they in fact collect their information.

But the nice thing about registries is, even though you might have to report back on patients that you saw earlier in the year, you can do that through registries, whereas obviously through claims, you know, once your claim is gone, that's it. And no one's ever going to hold claims...

Christina Martini: So I can still file the PQRI through the registry even though I have this problem...

Dan Green: Yes.

Christina Martini: ...and still get credit?

Dan Green: Because the registries will report your aggregated calculations to us and if you successfully report based on their calculations, then yes, you would still be incentive eligible.

Michael Rapp: So we have several alternative reporting - we have two alternative reporting periods and different mechanisms or criteria for reporting. So you can report all of these different ways.

So you could report for one reporting period and other different measures and so forth, but what I think for 2008 we have nine different combinations.

But we looked at everyone one of them and which ever one the individual professional succeeds at that's what we give them credit for, whichever's most favorable in terms of the incentive, we do that. So...

Christina Martini: And you were saying early that you have to have a zero on - zero point zero. It can't be left blank, the...

Dan Green: What you want to do is; a lot of programs will reject the zero charge, so you're better off just putting a 1 cent charge in and that way it'll get rejected, but at least it'll go through from a claims standpoint. But at this point, you're best bet since we're in November, might be to contact a registry, because again they're - you could...

Christina Martini: Yes.

Dan Green: ...go back to all your charges and submit them the proper quality data codes for the patients you saw.

Christina Martini: And you were referring to a bunch of slides which I, according to the email I got was only phone information. A phoned conference, so can you give me like the Website, or contact, you know, or the contact information you were - some place that I could refer to this conference call, because I could not get into any slides or any that you were referring to with a lot of emails and different information?

Rebecca Donnay: Dr. Newell, can you provide that information to the caller?

Richard Newell: Sure. What you will want to do is go to the Open Door Forum on the CMS Website. You'll go to the bottom and you can either click on CEP America's link, or ACEP's link, which will take you directly to the slides that were used for today's Open Door Forum.

Christina Martini: Thank you. And one final question. The N365, is that on with the regular remittance? Is that one of the codes like approval or denial code? Is that what you're referring to when you N365?

Michael Granovsky: That's correct.

Christina Martini: Okay. So next, on the claim, it'll appear N365? That you would know that it was gone through and it's fine?

Michael Granovsky: Right. That's - this is Dr. Granovsky. That's correct. In fact, if you look back at your claims, you'll see that there was not an N365 and that's...

Christina Martini: Right.

Michael Granovsky:...would've been a tip off that those claims didn't make it...

Christina Martini: Right.

Michael Granovsky: ...into the National Claims History File.

Christina Martini: Okay. All right. Thank you for your help.

Operator: Your next question comes from the line of Todd Thomas from Oklahoma. Your line is now open.

Todd Thomas: Thank you. This is Todd with (unintelligible) Incorporated. Mike, I just wanted to kind of clarify your slide number 49 with the dollars received for PQRI. The lead inside seems to be numbers for the entire PQRI program. Are the numbers on slide 49 specific to emergency medicine?

Michael Granovsky: The numbers on - that's correct. The numbers on slide 49 - 2007 with a total of $36 million distributed, but no, not specific to emergency medicine. This is across the whole country, national data.

Todd Thomas: We have a feel for what the 2008 numbers would be?

Michael Granovsky: I would defer to my CMS colleagues on the call since that information isn't public.

Michael Rapp: Yes. We haven't made that information public, but we expect it to be announced by the agency soon. The $36 million for 2007 was for all of the participants in the program. I can tell you it's very substantially higher than that for 2008, but we haven't released that information yet.

Dan Green: And remember that 2007 was a six month reporting period, not a whole year.

Todd Thomas: Right. I still come across groups that aren't doing PQRI and this time of year I'm trying to get them to do it in preparation for next year and usually the first thing is, you know, what's in it for me. So just trying to give them...

Michael Rapp: A lot of different things, but certainly the incentive is part of it and for 2010 it's the same as it was for 2009, which is 2%. So the figure you have initially was 1-1/2% for half a year. This 2008 figure that you hear will be for the entire year and also 2% and that'll be for 2010 as well.

How much an individual will get of course depends on how much are their billings because it's a certain percentage of the overall billing, so in that respect it will directly mirror whatever payments one gets from Medicare in the first place.

Todd Thomas: And one other quick question for the provider feedback report. The list of call numbers seems to be just the provider, the carrier main number. Is there a specific process a provider should go through to get the provider feedback report or just talk to whoever happens to answer the phone that day?

Michael Rapp: I believe they should just, you can talk to whoever answers the phone and they have a script and know how to process these calls.

Todd Thomas: Okay. Thank you very much.

Natalie Highsmith: Mason, next question?

Operator: Sorry. Your next question comes from the line Abbey Mehrotra from North Carolina. Your line is now open.

Abhi Mehrotra: Good afternoon. Thank you for taking for my call. This is Abhi Mehrotra from North Carolina - University of North Carolina, Department of Emergency Medicine.

Two questions for you, and I apologize if the first one was already covered. When do you expect the payment update for 2007 information and the update itself to be released along with the 2008 payment?

Michael Rapp: The 2008 incentive payment had been made for the most part and there is one carrier I believe that didn't complete the payments, but for the most they've already been made.

Secondly, for the 2007 additional Re-run that we did, those payments are going out this month. They will, I believe they've already started, but it'll take about three weeks to complete them all.

Abhi Mehrotra: So we should be able to check online for the 2008 payments if it's already been made to see if our providers will be receiving one?

Michael Rapp: Well, the first thing you can do is go to the feedback reports, so you actually will not get information from, if you're talking about online for the feedback report. Is that what you were asking?

Abhi Mehrotra: Yes.

Michael Rapp: So yes, the feedback reports will indicate how much the incentive payment for each individual.

Abhi Mehrotra: Okay.

Michael Rapp: Or of course, as I mentioned, as individuals they can go and call their carrier and get that information.

Abhi Mehrotra: Thank you. Second question I had and it was a concern and Dr. Granovsky, thank you for bringing that up during the presentation, what the claims based reporting issue. When we internally looked at our data for our 2007 payment, there was a discrepancy between our internal data and what the CMS reporting was.

And we believe it was due to the intermediary and problems with codes being stripped when they were being reprocessed or submitted again. My concern lies with where we think that this process is moving towards, going towards public reporting and given that potential implications for that with an imperfect process and how you (have them) public physician reporting with this claims based reporting system.

Could you comment on that, Mike or Dr. Beck?

Michael Rapp: So, first of all, there's an issue about the data that's reported and I'm not sure what the discrepancy you're talking about here. Is the discrepancy in the amount of physician fee schedule charges or the discrepancy in what?

Abhi Mehrotra: There's a discrepancy in the PQRI qualifications, so we had - certain of our providers were not - were listed as, quote/unquote, "not qualifying" for the incentive payment, because they didn't meet the thresholds.

Whereas our internal data reflects that they did, but it was a billing issue where codes were bounced back and then resubmitted but resubmitted without the featured I codes from our billing company.

Michael Rapp: Okay. So, I'm not sure if I followed that exactly, but for 2007 we did do some analytical fixes after reviewing that entire process where there were claims that were split off.

The CPT code was split off from the claim and came in what we refer to as an orphan claim. We figured out a process that will bring those back together but based upon making sure we're talking about the same patient, the same date of service, so forth. So we did that and that was the context of the re-run.

Abhi Mehrotra: Sure.

Michael Rapp: So, if a person did not qualify for 2007, we looked at their information all over again, and if they qualified then they would get a payment. If there's this 80% threshold if you met that we didn't re-run it because the amount of money wouldn't be affected by the issues that you bring up.

In regard to public reporting of performance information, this of course is merely the information we made publicly available is whether a person participated.

That's what we did last year, and that meant anybody who submitted quality data code once, whether or not even it was a valid quality data code, we identified them as quote, "participating in the program."

There is no proposal we made to make this information - the performance information in particular - publicly available. That presents quite a number of issues, particularly the individual physician level.

I look in terms of public reporting at the group level as the first step in this sort of thing. But even that we don't have any specific plans for that with regard to PQRI since the reporting of the PQRI really is at the individual level at this point.

We did consider making that a requirement for the group practice reporting option for 2010. We proposed that in the rule, but we got a variety of comments on that, that would say generally speaking, physician organizations were against that, although consumers were in favor of it.

In that case we would consider only public reporting at the large group levels, 200 or more physicians. But we were persuaded that we were better off to consider that a bit more fully before moving in that direction. But we have not to date proposed any individual reporting.

It does raise even, certainly more issues in part because the numbers are small, frequently for individuals and we don't want to do anything that would be not fair or somehow misleading. There's the issue of having doctors review that information before making it publicly available.

So I wouldn't assume that we're going to do this anytime in the near future. But, of course, it is about quality measurement. At this point it's collect the information, analyze it, feed it back to the doctors. We're not ready to move ahead with public reporting at this point for physicians.

Abhi Mehrotra: Thank you Dr. Rapp.

Operator: Your next question comes from the line of Mandy MacMannan. Your line is now open.

Mandy McManaman: Hi, this is Mandy. I am with Ophthalmology Group Practice in Kansas. We went to go access our feedback reports and found out that our security official was deleted.

When I called in they told me that I needed to setup a backup security official and I've been working on it for a couple of months now. And my ticket number has been reassigned because it's been timed out. Do I have any other options?

Michael Rapp: Have you called back the help desk about that?

Mandy MacManaman: I've called every day for the last two months.

Michael Rapp: How many ophthalmologists are in your practice?

Mandy MacManaman: Two.

Michael Rapp: You could have each of those use one of the alternate mechanism I mentioned.

Mandy MacManaman: I've called in and they told me no because we were registered as a group.

Michael Rapp: The individual, not you. Those two ophthalmologists - if they get on the phone and call the carrier, the carrier will make arrangements to email them the report. Each of them individually.

Mandy MacManaman: Okay.

Michael Rapp: So have each one call the carrier, they'll want to make sure they know who they're talking to, and then they'll gather some information, including an email address, and it'll take a little bit of time to process that. But over the next couple of weeks, anyway, they should find that they'll get the report emailed to them.

Mandy MacManaman: All right. Thank you very much.

Michael Rapp: Okay.

Operator: Your next question comes from line of Carol Aiken from Alabama. Your line is open.

Carol Aiken: Hi, Carol Aiken with the Emergency Room Physician's Group, Huntsville Hospital. And I apologize in advance. I know that this question was already asked.

However, I'm still unable to find those handouts you're discussing on the CMS Website. I was not given any directive in my information that I received to access those either. I followed the directions to the Open Door Forum, and the only thing I could find is just the announcement about today's forum.

Richard Newell: This is Dr. Newell. You can go the ACEP website and find them or you can go to www.cep.com, click on News and they will be right there under the November 2009 Emergency Medicine PQRI Open Door Forum.

Carol Aiken: So you said cep.com?

Richard Newell: Yes.

Carol Aiken: Okay, I will try that. Thank you.

Operator: Your next question comes from the line of Marcy Lugo from Florida. You line is now open.

Marcy Lugo: It was the same question. Thank you. On the slide. Disregard. I have no further question.

Operator: Your next question comes from the line of Christina Martini from New York. You line is now open.

Christina Martini: Hi, this is Christina Martini from New York. I work for People's Performance Physical Therapy. I have one final question regarding the diagnosis codes under the PQRI. Are they only supposed to be pertaining to a slip and fall or can it be all diagnosis codes for that patient?

Can they still be listed on the PQRI code? Do we have - in other words, do we have to only choose the code regarding a slip and fall pertaining to the PQRI code or do we list all procedure - all the diagnosis codes?

Dan Green: So you can, I mean you list all the diagnosis codes that are pertinent for that particular patient.

Christina Martini: Okay, that's what I wanted to know. I didn't know if it just had to be a...

Dan Green: But you have to include the codes that would put the patient in the denominator of the measure. Do you know what I'm saying?

Christina Martini: Right. If in other words if they had fallen it could be because of the, you know, walking...

Dan Green: Well, whatever the CPT code is and or diagnosis that helps to put them in the denominator, which would definitely need to appear on the claim. Again, you can have additional diagnoses, but you need to make sure that you at least have that *one* code because that's how we know that patient comes - is in the denominator of that particular measure.

Christina Martini: Okay. All right. Thank you very much.

Dan Green: Thank you.

Operator: Once again, if you have any questions press star then number one on your telephone keypad.

Your next question comes from the line of Todd Thomas from Oklahoma. Your line is now open.

Todd Thomas: Hi, Todd Thomas with New York code. I just want to clarify for the provider feedback reports. The provider themselves have to call the carrier, it can't be done by representative from the office?

Dan Green: Each provider can get their individual level feedback report. So the provider would need to call. They want to authenticate, make sure the provider is the person to whom they are trying to get the feedback report - or for whom they're trying to get the feedback report. So, you know, once you have the report of course you can share it with whom you choose.

Todd Thomas: Okay, thank you.

Dan green: Thank you.

Operator: Your next question comes from the line of Peggy Gunnings from Tennessee. Your line is now open.

Peggy Gunnings: Hi, this is Peg Gunnings with Term Billings in Texas. And my question is for 2009 reporting, if a provider is reporting utilizing that claims-based reporting of individual measures options and specifically you're reporting on six measures, and three of those are three of the four pneumonia measures. Is it acceptable to do that or must you report all or none of the four pneumonia measures?

Dan Green: You can report the three of the four. It's no problem. You know, we applaud your efforts with the reporting of six measures. That way, if you fall below 80% on any one or two you still potentially could qualify for an incentive.

But you only need to report all four measures if you're intending to report a measures group. So you could report three of those four individually and again if you're reporting more than 80% of the eligible instances you should qualify for an incentive.

Peggy Gunnings: Okay. Thank you very much.

Operator: There are no further questions at this time.

Natalie Highsmith: Okay. I will turn the call over to Dr. Green for closing remarks.

Dan Green: I'd just like to thank everyone for your participation today. I think you know, we're very excited that the emergency room physicians are so engaged and interested in PQRI and the questions today were wonderful and I hope they helped to clear up some of these issues. I also really would like to thank Drs. Newell - excuse me - Granovsky, and Dr. Beck for their insight and assistance today, not only in presenting this material but also in putting together these terrific slides.

So we hope that it's been helpful and we look forward to your participation and if you have other questions we do have monthly national provider calls and we invite any and all of you to participate in those calls as well.

So thank you very much to everyone for your participation today.

Natalie Highsmith: Okay. Mason, can you tell us how many people joined us on the call today?

Operator: We had a peak amount of participants at 177.

Natalie Highsmith: That's wonderful. Thank you everyone.

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

END