Centers for Medicare & Medicaid Services
Special Open Door Forum:
Electronic Prescribing Part 2
Thursday, December 11, 2008
3:30pm-5pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) is hosting a second Special Open Door Forum (ODF) on Electronic Prescribing (E-Prescribing). CMS staff will again present information on the following topics: Overview of Part D E-Prescribing Standards, E-Prescribing Resources, E-Prescribing Incentives and E-Prescribing Measures.

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes a new and separate incentive program for eligible professionals who are successful electronic prescribers (e-Prescribers) as defined by MIPPA. This new incentive program removes the e-prescribing measure from the Physician Quality Reporting Initiative (PQRI) for 2009.

For more updated information about E-Prescribing, please visit: http://www.cms.hhs.gov/EPrescribing/ and visit the E-Prescribing Incentive Program webpage http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage

We look forward to your participation.

Open Door Forum Instructions**:**

*****Capacity is limited so dial in early. You may begin dialing into this forum as early as 3:15 PM ET.*****

Dial: 1-800-837-1935

Reference Conference ID: 71918561

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html . A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning December 19, 2008 and available for 30 days.

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.

Centers for Medicare & Medicaid Services
Agenda
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Electronic Prescribing Part 2
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Welcome & Introduction of Presenters
-Natalie Highsmith, Office of External Affairs (OEA)

E-Prescribing Qualified System Standards
-Dr. Daniel Green or Dr.Mike Rapp, Office of Clinical Standards & Quality (OCSQ)

E-Prescribing Measure #125
-Dr. Daniel Green (OCSQ)

Consumer Support- AARP Research Findings
- Jennie Gladieux, AARP

Open Q&A

Closing Remarks

Audio file for this Transcript:
http://media.cms.hhs.gov/audio/SpcODF_ePrescribing_2.mp3

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum: Electronic Prescribing Part 2

Moderator: Natalie Highsmith
Conference Leader: Dr. Michael Rapp
December 11, 2008
3:30 pm ET

Operator: Good afternoon. My name is (Amanda) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services special open-door forum electronic prescribing Part 2. All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you Ms. Natalie Highsmith, you can begin your conference.

Natalie Highsmith: Thank you (Amanda) and good day to everyone and thank you for joining us for this special open-door forum on electronic prescribing Part 2. I'd like to thank all you all again for joining us as we get closer to the holiday season.

First, we will hear from Jenny Gladieux who is from AARP, and she will talk about Consumer Report, which is a customer - Consumer

Report AARP research that has been done on electronic prescribing. Jenny.

Jenny Gladieux: Yeah, thank you. We did a study called Healthy at Home, which is available on the AARP Web site at aarp.org, and this study surveyed about 900 people who are age 65 plus. And, it found a surprising amount of support for ePrescribing. It found that more than nine in ten wished the doctor could perform typical ePrescribing tasks such as checking whether their insurance covers a specific medication before writing the prescription, checking their medication history, or sending prescriptions electronically to the pharmacy to be filled for pick-up.

We also surveyed caregivers who are age 45 to 75 and they - and about 80% also supported the use of ePrescribing. And that's about it.

Natalie Highsmith: Okay, thank you Jenny. And I forgot to remind our participants that the agenda has been posted on the special open-door forum Web page, if you go to www.cms.hhs.gov/opendoorforums with an s. Click on the special open-door forum link that's on the left-hand side of the page and the agenda will be under the download section.

Next, we will hear from Dr. Michael Rapp who is in our office of clinical standards and quality, and he will talk about the ePrescribing qualified system standards. Dr. Rapp.

Michael Rapp: Thank you Natalie. Yes, welcome everyone. Good afternoon to you. We're getting close to the time that the electronic prescribing incentive program starts for 2009. I'm gonna quickly run through the background for this, and then we'll get to the components of what constitutes a qualified system and how the measure works.

So, essentially, the electronic prescribing incentive program is a separate incentive program that Congress passed with the MIPPA legislation in July of this year. ePrescribing is the transmission using electronic media of prescription or prescription-related information between a prescriber, a dispenser, pharmacy benefit manager or health plan, either directly or through an intermediary, including an ePrescribing network.

So, what we're talking about is a three-way communication, not just the physician turning a prescription into an electronic message as opposed to writing it, but a three-way communication between the professional and the pharmacy and the pharmacy benefit manager.

There are many potential benefits to ePrescribing, but so far, there's limited adoption, and the Medicare Modernization Act with the prescription drug benefit program, Congress required and promoted the use of electronic prescribing by requiring the adoption of interoperable Part D standards.

We have the representative from the group that handles that here, Drew Morgan, who could answer any questions about the Part D standards for us.

The MIPPA legislation provided for a 2% incentive payment for physicians and other eligible professional who electronically prescribe and report electronic prescribing measure. Incentive payment is available for 2009 2%, 2010 2%, 2011 1%, 2012 1%, 2013 1/2 of 1%. There is a parallel future fee reduction penalty starting in 2012 at 1%, 2013 1 1/2%, and 2014 and beyond 2%, and that penalty is indefinite. There is no termination of that penalty.

The fee reduction would be perspective based on a prior reporting date that hasn't yet been determined, but won't be before 2010, so it's not relevant for 2009. There is a hardship exemption available for professionals when we get to the penalty provision. The eligible professional is basically anyone eligible under PQRI, but since PQRI includes certain practitioners that don't have prescribing authority, the electronic prescriber incentive program would not apply to professionals without prescribing authority.

There is a requirement in order to qualify for the - as a successful electronic prescriber, one needs to report a measure, and this is a measure that was in the PQRI program, subject to some modification. And, reporting of that measure has to occur for at least 50% of applicable cases, and we'll go through the measure and what has to be reported.

There is abundant detail about the program in our physician fee schedule 2009 payment rule. There's quite a bit of detail about the electronic prescriber program, really more than would normally be provided in a rule, but this was done because it was a new program.

Although the ePrescribing measure was available in the PQRI program in 2008, Congress directed that that measure be removed from the program and a separate electronic prescribe incentive program be developed based upon that measure.

The electronic prescribing measure has some basic components to it. I'm gonna let Dr. Green go through the details of both what a qualified system is and how the measure works, and I'm gonna cover it at higher level, and he will cover the details.

But, the overall requirement in reporting is that the physician or other eligible professional is reporting that they have adopted and put in place a qualified electronic prescribing system. If they do not have an electronic prescribing system that they've implemented, there is nothing to report.

There is a reporting denominator, which are those situations where the measure is reportable, and essentially that deals with office visit codes, so that whenever one of those office visit codes - which Dr. Green will go into - is placed on a claim, an occasion arises to report the electronic prescribing measure.

So, it's not directly related to prescribing or electronic prescribing. The time to report the measure is when the office visit occurs that one bills for. When that occurs, there's a reporting numerator. Those - that reporting numerator is three G codes. The G codes are essentially all prescriptions were electronically prescribed using a qualified system.

The qualified - the second G code is a qualified system is available, but no prescriptions were issued, or third, some or all of the prescriptions were not electronically prescribed for a bona fide reason indicated in the measure such as, pharmacy couldn't receive it, patient request, federal or state law or regulation, or it was a narcotic.

So again, there are four components to the qualified electronic prescribing system that Dr. Green will go into. In addition, for those four functionalities, the ePrescribing systems must be compliant with Medicare Part D standards. Medicare Part D standards are the electronic messaging standards to transmit information about prescription. Those Part D standards have to be used for the functionalities that are required. There are Part D standards or

functionalities that are not required through the measure Dr. Green will discuss.

In terms of selecting a system, there are a few shorthand ways that one can determine if they are purchasing a system that meets the functionalities required for the measure. There is no list of qualified systems that CMS maintains. We are not "qualifying systems". Essentially, what happens is the physician or other professional in submitting the G code is stating that they have qualified system and that the other aspects of the use of the system have taken place as are reflected in the G code.

In order to know whether your system has the functionalities of course, and the most obviously way is to discuss with the vendor and understand the functionalities included in the system. There is a shorthand way for prescript - electronic prescribing modules that are part of an EHR system in that CCHIT certification for 2008 has requirements such that if an EHR system was a ePrescribing module has 2008 CCHI certification then, it does have the four functionalities we're talking about.

The other type of ePrescribing system is a stand-alone system. There is no CCHIT certification for stand-alone systems, so one has to deal with the vendor on that. But, we would expect or we do expect in 2009 that CCHIT may have (unintelligible) certification for stand-alone systems. Pending that, one needs to discuss that with the vendor.

As far as whether the system meets Part D standards, a shorthand way of doing that is seeing if the vendor system uses the SureScripts RxHub network. These vendors are listed on the SureScripts RxHub Website, and if they are listed there, then we are informed that our D

standards are used by those vendors. That is not to say that we advocate necessarily using a system that uses that network. That's up to the practitioner in terms of what system to get. That is a shorthand way. If one is using a system doesn't use that network, then one has to determine from the vendor in fact, if the Part D standards are used by the product.

We have in the physician fee schedule rules for 2008, detailed information on the Part D standards that are relevant to the four functionalities and specified and specifically for those four functionalities. So, if one wants to find out exactly what Part D standard we're talking about, one can refer to the physician fee schedule.

We'll have abundant information on the Website and Dr. Green will discuss that.

In terms of for the future, this program will change over time likely, specifically with regard to how the measure works and how the incentive payment program works. Specifically, right now a measure from claims is how one determines a successful electronic prescriber. For the future, we're hopeful, based on the authority that Congress provided the Secretary to instead base the incentive program on the number of Part D prescriptions a physician writes or number of prescribing events, and the incidents of electronic prescribing.

We hope to get to the point where we can get that information from the Part D event data, the so called PDE data - in other words the claims data that is submitted by the pharmacy benefit manager in connection with the Part D plans so that based upon that claims data, not anything

that the physician directly submits, we could learn whether the physician's electronic prescribing.

When we get to that point - assuming we do - then it won't be necessary for the physicians report the measure using claims, but they will simply electronically prescribe an incentive (unintelligible) will be able to be made.

So at this point, I'm gonna turn it over to Dr. Green. He will go into details of the electronic prescribing qualified system standards and go into details of electronic prescribing measure. We also, as I mentioned, have Drew Morgan here with us and he may have a couple of points to make about the Part D standards, certainly if he feels that we misstated it in any way. But, I'll turn it over to Dr. Green right now.

Daniel Green: Thank you Dr. Rapp. Welcome everyone. Briefly, as Dr. Rapp explained when he was doing his presentation, you have to have a (unintelligible) of qualified ePrescribing system to be able to report anything. So what - how do we define a qualified ePrescribing system?

While the measure specifications are posted on our Web site at www.cms.hhs.gov/pqri and it's - they're listed under the ePrescribing tab, which you can find on the left-hand side of that initial page. And if you look at the ePrescribing specifications, you can see that a qualified system has to have four functionalities.

The first is it has to generate a complete and active medication list incorporating electronic data, which is received from applicable pharmacies and benefit managers, if this information is available, that is if the PDMs and pharmacies have the information to send back to

the system. In either case, the system has to be able to receive the - this information.

Additionally, a system has to be able to select medications, print prescriptions, electronically transmit the prescriptions, and conduct alerts. And these alerts are defined as written or acoustic signals which warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interaction, allergy concerns, or warnings and cautions.

Now, the third and fourth qualification are very - qualifications are very similar for 2009 and basically, the third qualification is that the system be able to provide information related to lower cost therapeutically appropriate alternatives if any exist. For 2009, we are accepting that the system is able to receive formulary information - excuse me - to satisfy this requirement.

The fourth requirement is that the system be able to provide information on formulary or tier-formulated medications, but it also includes patient eligibility and authorization requirements which are received electronically from the patient's drug plan, again if this information is available.

So, if a provider wants to take part in the electronic prescribing program for 2009, they have to have a - an electronic prescribing program that is capable of doing these four functionalities. In addition to that, the system must be - must carry out these functionalities using the Part D standards.

Now, the Part D standards are like a version of software basically, that transmits the required messages and/or receives the required messages from the pharmacy or pharmacy benefit manager. So, Dr. Rapp, in one of the previous calls, gave a great example - analogy that I thought was wonderful.

If you think of the system or the functionalities as the components of a computer, like you want to have a word processor on your computer, you want to have a slide presentation on your computer, you might want to have a financial program on your computer. And then if you think of the Part D standards actually as the actual type and version of the word processing program or financial spreadsheet, so you might, for your financial spreadsheet, use Quicken. You might use Word for your word processor.

So the Part D standards would be similar to the actual program and the version of the program whereas the functionalities would be a little bit of a higher level and describe more the actual types of programs you would want on your computer. I thought that was a great analogy and I hope he doesn't mind I adopted it for today's call.

Michael Rapp: Actually, I think I took it from you Dan.

Daniel Green: But in any case, so the second thing a provider should do is they should look at the codes that comprise the denominator, and you can see that these codes - there are psychiatric codes, some i-care codes. There are some evaluation and management codes for new patients as well as follow-up established patients. There are some consultation codes that occur in the office. There's a pelvic exam as well as diabetic teaching codes that it - all appear on the denominator of the measure.

So, a provider needs to look at these denominator codes, and one of the requirements for an eligible professional to report the ePrescribing measure for 2009 is that the charges that make up the denominator of the measure are at least 10% of the providers Medicare covered Part D charges. In other words, if you have a gastroenterologist that does $100,000 of Medicare part D covered services and $85,000 are from colonoscopies and $15,000 are from code that make up - that appear in the denominator, that provider would be eligible to report this measure.

If on the other hand, only $5,000 in charges are made up of codes in the denominator and $95,000 are due to colonoscopies, that provider would not be able to report on this measure.

And, I should clarify. Anyone is able to report on the measure; however, to qualify for the incentive payment, they need to meet the 10% threshold. So, even if you don't fall into the category of meeting the 10% of your charges of that appear in denominator, we would still encourage you to report this measure in general. We will determine at the end of the year in terms of whether a provider actually reaches the 10% threshold.

So, when you look at these denominator codes, if you're seeing a Medicare Part D patient and your billing one of these services, and you have a qualified electronic prescribing program, you need to be able to report one of the G codes on the - on your claim. And, it's required that you report on at least 50% of patients who - for whom you provide one of these services. We encourage you to report on all your patients to ensure the best chance of success of reaching and passing the 50% threshold and earning an incentive payment.

As Dr. Rapp explained in his presentation, there are three G codes that can be reported. The first one again, as he said, means that you - all the prescriptions that you generated during - for this visit were sent electronically using a qualified system. The second G code basically says that no prescriptions were generated during this encounter with the patient.

And then there's a third separate G code that says for one reason or another, some prescriptions were printed or phoned into the pharmacy. And this could occur if it's required by federal or state law or regulation, if the patient requests.

So if the patient, for instance, lives in a northern climate and is going to Florida for the cold months and says, well, I'm not really sure which pharmacy I'm gonna use. Can you just write it out for me? That's an acceptable reason to report this other G code. It could be that you're prescribing controlled or - controlled substances or narcotics, and again, that is also an acceptable exclusion.

The final acceptable exclusion would be that if the pharmacy's unable to receive electronic transmission. If you choose not to report because you just don't feel like it that day, you don't feel like booting up your system or what have you, that is not an acceptable exclusion. You just couldn't report anything on that particular claim, and that would count in the claims kind of against trying to achieve the 50% if you will.

So, we will be having - on our Web site - a document called ePrescribing made simple and it's a very - it's about three pages, very easy to read and it's pretty much a step-by-step paper that shows you how you can report the ePrescribing measure. And for those of you that are interested in more information, I would encourage you to look

at it. It's not up just yet, but we hope to have it up some time by the middle to the end of next week. And again, I think it will help to clarify things for you.

And now, I'm gonna turn it back to Dr. Rapp or to Drew if Drew has any comments about the Part D standards.

Drew Morgan: All right. One thing I wanted to say about the Part D standards we did come out with some new standards that go in effect on April 1, 2009. That final rule was published back in April of this year. And those new standards that we adopted were in formulary and medication history. We also adopted (unintelligible). We adopted the individual level MPI (unintelligible) used in ePrescribing, and we also adopted medication history. So, if you want to get yourself familiar with those standards, you can find that on our Web site at cms.hhs.gov/eprescribing.

And just want to let you know that ePrescribing is voluntary under Part D, but however, you know, if you choose to do ePrescribing, then those are the standards that you must follow. And so, to make sure when you're looking for a qualified system that they follow the standards.

Michael Rapp: Well, thank you very much Drew. I will turn it back now to Natalie Highsmith for the - I think we're ready for the question and answer.

Natalie Highsmith: Okay (Amanda), if you could just remind everyone on how to get into the queue to ask their question, and every please remember when it is your turn, to restate your name, what state your are calling from, and what provider, or organization your are representing today.

Operator: Once again, at this time, as a reminder, if you have a question, please press star and then the number 1 on your telephone keypad.

The first question is from Larry Ozeran from California. Your line is now open.

Larry Ozeran: Hi, Larry Ozeran in California with Clinic Informatics. I had a two-part question. You talked about eligibility and if someone is not eligible to report because of their case mix, will they still be penalized down the road after the penalties start to kick in?

The second part of that question is, if someone is a specialist who does meet the 10% criteria for ENM codes but they never prescribed, or the majority of the time, they're prescribing say, is for other codes like during post-operative visits, how - will those individuals also be penalized after 2013, even though they won't qualify for the incentives during the incentive period?

Michael Rapp: Well, let me address a couple of those. In terms of eligibility to report, anyone can report. It's the eligibility for the incentive payment, I think, is what you're referring to which is that...

Larry Ozeran: Correct.

Michael Rapp: If you report 50% of the time but 10% of your Part B allowable charges are not represented by the codes in the denominator, then you're not eligible - then you will not receive the incentive payment. There is a - it's called a limitation.

So, that same limitation applies to the penalty in the future. The only nuance there is that we could change from the measure based upon the

denominator codes currently to something else, but I think the point that you're making is one that a lot of people are concerned about, which his, well, how exactly will this penalty work.

And I think the main thing I can tell you at this stage is that, that's a bit yet too determined. It will be the subject of rule making in the future, which means it's something that the Secretary would propose. But, it would be commented on by the public and an element of this would certainly be fairness. If a professional were not eligible for the incentive payment, there is a certain amount of balance there I think that the statute contemplates, which is that they shouldn't be subject to the penalty.

But all this will be the subject of future rule making, the parameters of the penalty are not laid out. There is specifically a hardship exemption that the Secretaries can apply. How that would be applied, again would be subject to future rule making again, something that would be proposed but commented on by the public, and only after that and taking into the council's considerations would the final rule be published. And do doubt, there would be comments that would come in suggesting that balance should be applied.

So, I can't give you a chapter and verse about how the penalty will work. I can only tell you how the incentive payment will work for 2009.

Larry Ozeran: Thank you.

Daniel Green: With respect to your second question about the provider who may be a specialist but who does fall into the denominator for more than 10% of their measures, but the majority of their prescribing occurs in the

hospital or is not in one of the codes that appear in the denominator or the measure, that provider, if he or she has an - a qualified system - as we discussed earlier - and if they do report the measure on those - for those service codes that do appear in the denominator, whether or not they prescribed or not, they still could be eligible for the incentive payment.

So, again, there will be instances where no prescriptions are generated for instance, and that may be what your kind of eluding to or describing.

If they fall into the denominator and they report on at least 50% of those eligible cases, and of course, they have a qualified electronic prescribing system which they normally use, they should be able to not only report but receive the incentive payment.

Michael Rapp: And actually carrying it to the extreme, there's no requirement that one or another of the G codes be the one that's reported. You get - one gets credit for reporting if they report any one of the three G codes, and one of the three G codes is no prescriptions were generated in this visit. So, it's theoretically possible for one to have an electronic prescribing system, but in all of the instances where one reports, they report that no prescriptions were generated at this visit.

That would meet the reporting or the measure, but of course, it wouldn't mean - meet the intent of promoting electronic prescribing, but it wouldn't 0- it would meet the technical parameters of the measure.

Larry Ozeran: Okay, thank you.

Operator: Thank you. The next question's from Cathy Daboul from New York. Your line is now open.

Cathy Daboul: Yes, hi. My name is Cathy Daboul. I'm from River Valley Family Medical Services. My question is on - first of all, how do you determine the 10% threshold?

There was a problem this year when doctors changed from provider I.D. number - the Medicare provider I.D. to an NPI number. Our office was like that, so our numbers got split up. So in the beginning of the year, we were reporting under the Medicare provider I.D. and then starting May, we - our reporting went to our rendering NPI number and group I.D. number.

How is that determined at the end of the year? Will I get, you know, will you count the medi - the previous Medicare provider I.D. or will you count it together along with the NPI number of the doctor? I, you know, please explain.

Michael Rapp: Are you asking about the 2009 electronic subscriber incentive program?

Cathy Daboul: Yes. We have an electronic health record and we started reporting starting in January. But what had happened was, we started reporting with the Medicare provider I.D. number, January to May. From May, we were not able to send claims out because our numbers changed because of the NPI numbers.

So once we got our NPI number, our reporting went to that NPI number. We were always reporting with the rendering provider, but we had a problem with the group I.D. number whereas Medicare had a

group I.D. (unintelligible) and also the doctor's I.D., so I was just wondering at the end of the year, how would the - how is that going to affect all of the reporting including ePrescribing?

Michael Rapp: Well, yes. I was just trying to clarify what year you're talking about because you were talking about (unintelligible).

Cathy Daboul: 2009 - I mean, 2008.

Michael Rapp: Okay. So the electronic prescriber incentive program doesn't apply 'till 2009 so...

Cathy Daboul: Okay, so it not a...

Michael Rapp: It starts July 1, 2009, so let's go to the - excuse, January. I misspoke. Thank you.

Cathy Daboul: For 2008, I thought you said there was 2% back.

Michael Rapp: Okay, let me just clarify it. So, we had a physical quality reporting initiative that was for the second six months of 2007, so that's...

Cathy Daboul: Right.

Michael Rapp: We had one for 2008 that's ongoing.

Cathy Daboul: Right, 2007 you did not have ePrescribing I believe.

Michael Rapp: (Unintelligible). We had ePrescribing as one of the PQRI measures in 2008...

Cathy Daboul: Right.

Michael Rapp: ...but this electronic prescriber incentive program, 2% for that starts January 1, 2009. So let me get to the MPI though. I understand the point that you're making.

For 2008, since that's the year you were talking about, there was a time that you could get paid on your claims without submitting the NPI.

Cathy Daboul: Right. We submitted...

Michael Rapp: Oh, I understand that. But I've got a - I'm just trying to recount it. And, starting however, April - March 1, 2008, there was an edit put in place so that if you submitted a claim without a rendering NPI, that claim was not processed.

Cathy Daboul: Right.

Michael Rapp: It was returned.

Cathy Daboul: Right.

Michael Rapp: Therefore, for the PQRI program itself, let's - so let's jump ahead to 2009. There is an edit in place. You cannot do what you did earlier so it will be irrelevant. All of your - all of - the only analysis that's done - that is done for the electronic prescriber incentive program or PQRI for any time was at the NPI level. But that won't be a issue for 2009. None of your claims will get processed and none of you electronic prescribing reporting nor none of your PQRI reporting will be considered unless you have an NPI with it.

Now, let's go back to 2008. For 2 - well, I will go back to 2007. For 2007, there was no edit in place, and in 2007, there nevertheless was a requirement that for the PQRI program, the NPI be submitted. If the NPI was not submitted, the quality data code was not considered nor was any claim on which the incentive payment would be based considered. That affected about 12% of the quality data codes in 2007. So that was an issue; however, we are pleased that for 2008, that does not appear to be an issue.

Overall, about 1 1/2% or so or a little less than that of claims for the first couple of months of 2008 were affect - (unintelligible) first three months of 2008 were affected by that NPI issue. In other words, the quality data codes were submitted without an NPI. Those won't be considered for 2008, but starting March 1, all of the claims will have had an NPI.

So, in your particular situation for 2008, although there were a number of claims you submitted early in the year that won't be considered, it shouldn't have a significant impact on the success of your reporting for 2008, and that's the general case. For 2009, it's irrelevant. So, did that answer your question?

Cathy Daboul: Yes. My - the - there's two NPIs that we report. There is a group NPI and a rendering provider NPI, and I believe that the rendering provider NPIs were there already, even in the beginning of the year.

Michael Rapp: Well, I'm pleased to hear that and the reason that that's the one that's important is because under the physician quality reporting initiative and under the electronic prescribing incentive program, through 2009 all eligibility for an incentive payment is determined at the individual professional level and all incentive payments are determined at the

individual professional level, although the payments are made to the practice of the professional.

In other words, if there - if the professional's in a group practice, the payments would be made to the group practice, but the determination made at the individual level. Because it's made at the individual level, it's necessary to have individual identification and that is the reason to require the rendering MPI.

Cathy Daboul: Right. So that's - the line 24J matters when you do a claim because it those codes are on that line.

Michael Rapp: Right. I'm gonna have to refresh my recollection on what line 24J is, but the NPI - a rendering NPI can be placed with each line item, and that's what's normally done. So, that's where the rendering NPI - yes it is J there. So that's where the rendering NPI is placed.

Cathy Daboul: Thank you very much. That pleases me.

Michael Rapp: Okay. I'm glad it'll work out for you.

Cathy Daboul: Thank you.

Operator: Thank you. The next question is from Candy Weinper from California. Your line is now open.

Candy Weinper: Southern California Desert Retina Consultants, and I just want a little clarification that these qualifying codes would be used for each patient visit. If they come back two weeks in a row, we attach it to each qualifying visit. Is that correct?

Michael Rapp: Yes ma'am, that is correct. This is a per visit code and for that reason, 50% of every time one of those denominator codes is placed on the claim.

Candy Weinper: Would that also be true for PQRI, that it would be used for each visit, not just once in a year, but for every qualifying visit?

Michael Rapp: Are you talking about the electronic prescribing measure?

Candy Weinper: Well that's what - that was - my first question was the ePrescribing. My second part of that question is that true also for PQRI qualifying measures?

Michael Rapp: Well it - there's no uniform answer to that for each measure. The measures differ. They vary as to whether the measure is reportable once per reporting period, or with each visit, and one has to read the specifications of the measure to determine that.

Candy Weinper: Okay. Thank you.

Michael Rapp: We did provide a list for the 2008 PQRI measure, which indicates which ones are once per reporting period. I do want to point give you a little (unintelligible) there though. Once per reporting period means once per reporting period per patient for each doctor. So...

Candy Weinper: Right.

Michael Rapp: ...this is at the individual physician level. Therefore, if you have a group practice and even for the measures, which only are reportable such as diabetes measures, once per reporting period, if multiple

doctors see that same patient, each doctor needs to report for that patient.

Candy Weinper: Okay.

Michael Rapp: So it'll depend on the measure and one just has to look carefully what the - how the measure reads.

Candy Weinper: Okay, thank you.

Michael Rapp: You're welcome.

Operator: Thank you. The next question is from Joanne Koch from Michigan. Your line is now open.

Joanne Koch: Thank you. My name is Joanne. I'm from Michigan and I'm the owner of a billing company. I have like three questions and one comment. The first question is regard to my smaller practices that do not have an ePrescribing software product, but they have the ability to fax prescriptions via a computer. Would that qualify?

Daniel Green: No, that would not qualify.

Joanne Koch: Okay, because I thought I read an article recently that said it was gonna qualify.

Michael Rapp: Let me probably ask Drew to comment on that a little bit, but there's two aspects. One has to do with the Part D regulations and - which is perhaps what you're referring to and maybe that was discussed in the article. But, the measure requires certain functionalities and electronic

prescribing is non-defined as a computer generated fax. So, that does not qualify for the functionality or the measure.

There are sometimes when the physician electronically prescribes, but when it's received by the pharmacy, the pharmacy doesn't have the ability to receive it and (unintelligible) upon converts it a fax unbeknownst to the doctor. In that case, of course, that would count for electronic prescribing and one assert in the G code that they have electronically prescribed.

But it has to do with the initiation of the electronic prescribing message and if the physician initiates electronic prescribing, and that - and it would qualify. If the physician intends to send a computer generated fax, that does not constitute ePrescribing for the purpose of the G code, nor does it constitute ePrescribing for the allowable exceptions to electronic prescribing for the 3 G codes. Drew, do you want to add some clarification on how this computer generated fax issues has come up?

Drew Morgan: I think that was you're eluding to in the 2005, excuse me, ePrescribing rule, we had a couple exemptions. One of the exemptions we had that (unintelligible) it was place in the rule was this computer generated fax. And what we defined that was as a prescription that was generated by one of these prescription writer programs such as an EMR that wasn't using the script standard. And when we asked for comments, at the time, a lot of people came back and said, you know, this is cause us to revert back to paper if would not allow us to do this. So, we exempted it, in the hopes that eventually, the physicians would then upgrade to a true ePrescribing system.

Back in 2008 physician fee schedule, we proposed to lift that exemption as of January 1, 2009 (unintelligible) had several years to upgrade their systems in order to e-prescribe using the (unintelligible) script standard. After that rule was finalized, we got some comments back from industry with some concerns about certain of the ePrescribing standards that could cause them to cause undue burden on the pharmacy.

So in the 2009 physician fee schedule, we decided to keep that exemption in place for ePrescribing of the Part D. With the advent of MIPPA and the other programs, we felt like it was best interest of everybody to leave exemption in place and we will be lifting it 2012 when (unintelligible) incentive kick in (unintelligible) ePrescribing (unintelligible) so it give physicians or prescribers a longer time to upgrade their systems to the script standard in true prescribing.

Michael Rapp: So one issue has to do with the Part D standards, and I believe part of the rational for this was pharmacies getting refills...

((Crosstalk))

Drew Morgan: If the refill request, which is part of the script standard and part of ePrescribing, a lot of pharmacies they do one particular change that's got 150,000 of these requests a day chain wide, you know, nationwide, and that would cause them a problem because they would - have not - they wouldn't know which physician could actually receive them electronically. So it would cause a problem with - it would have them revert back to paper and have them send manual faxes which is not part of rule so that's why (unintelligible) decided to leave (unintelligible).

Michael Rapp: So just to point out the difference here, the issue that lead to not lifting the exemption was having - one major factor was this refill that came from the pharmacy. That is not how the incentive applies. We're talking about patient visits as opposed to a pharmacy asking for refills not in connection with a patient visit. So, it's sort of different situations.

We're talking about the situation where a patient is in the office, it's not a refill request by the pharmacy and it has to do with the physician generating a prescription. So that's why there's that distinction there. But just in short, using a computer generated fax does not constitute ePrescribing under the incentive payment or electronic prescribing.

Joanne Koch: Okay. That's was a nice long answer. The answer is no, and when the physician asks me can I e-fax, can I fax them, they can but it's not gonna be counted.

Michael Rapp: It won't count for the incentive program,

Joanne Koch: Okay, all right. Because they could have a patient in their office doing an office visit on one of the denominator codes, and still fax the prescription, it just won't be counted.

Michael Rapp: Well they can't - they cannot report a G code that indicates that they e-prescribed the prescription.

Joanne Koch: Okay, because there was an article in the Part D news that said something different. At least when I read it, I think it said something different that they preserved the exemption...

Michael Rapp: That's to the Part D standards.

Drew Morgan: That's (unintelligible) to the Part D standards.

Joanne Koch: Okay. So they didn't - they did not clarify that that was only for the Part D standards.

Michael Rapp: Right. So they - that is a little bit a confusing point, but they were probably accurate, but they didn't...

Joanne Koch: Tell the whole story.

Michael Rapp: ...make the next point that that's -doesn't have anything to - that that's not really applicable for the incentive payment program.

Joanne Koch: Well I will clarify it for my doctors that no. In order to do it, it has to be on a qualified one as outlined on your Website.

Okay, I have another question. Hospitalists, they use the electronic health records, they e-prescribe on a qualified system, yet they would rarely if ever do any of these denominator codes. But - so they would not qualify - ever qualify for their bonus.

Michael Rapp: Well, not necessarily. If hospitalists bill codes that - where the Part B charges for the codes comes to 10% of their overall charges, then they could qualify. Like, there are a number of hospital-type codes, admission codes and so forth that are not in the measure. These are professional office-type visit codes, but sometimes hospitalists see - may see patients in an outpatient-type environment where they would still meet the qualifications.

But in general as was set forth in the physician fee schedule rule, the focus of the measure is on that environment for physicians where number 1, most of the prescribing takes place, and second of all, where they have the ability to determine whether or not there is an electronic prescribing system in place. In the hospital setting, the hospitals are the ones usually putting it in the system rather than the physicians and the physicians are more a passive player there.

And we had some specific concerns expressed by members of hospital-based physicians that, in so far as this penalty would be somewhat parallel or there is a parallel penalty provision what is, with regard to ePrescribing that they may be subject to potentially to a penalty when they don't have the ability to control that environment. So, there's some policy reasons that as we - as the Secretary set forth in the physician fee schedule rules that lean toward having the denominator composed of professional office settings.

And I will also mention that these measures have gone through a rather extensive development process. At all phases of that measure development process, it was subject to public comment or open to public comment, both the development rule and AQA or AQA quality alliance adoption process, and finally through the (N2F) endorsement process. So the measure specifications were subject to a lot of public comment and there was a modification made based upon that. But this was not one that was made. There was - the hospital codes were not included.

Joanne Koch: Okay. I went on your - the Website and printed the 2009 ePrescribing incentive program guide, which outlines the three codes and the denominator codes. I also printed the FAQ sheet. It is ten - and then I

just want to clarify the 10% threshold. It's 10% of your payments that come from the - one of those denominator codes, not charges, correct?

Michael Rapp: It's total estimated allowed Part B charges.

Joanne Koch: Allowed, okay. So it's 10% of the allowed charges on only those denominator codes.

Michael Rapp: Right. So, if you take your whole universe of allowed charges...

Joanne Koch: Right.

Michael Rapp: ...for the reporting period, build as of two months after the close of the reporting period - in other words build as of February 28, 2010...

Joanne Koch: Right.

Michael Rapp: ...it's those charges and 10% of them have to be composed of the codes that are in the denominator. And if that's the case, then the physician is eligible for the incentive payment.

Joanne Koch: Okay. And then as far as the - you touched on this a little bit about whether you're going to - whether the bonus payment is paid to the group NPI, but the actual calculations are done on the individual NPI. So say, if I've got a group of ten docs...

Michael Rapp: Right.

Joanne Koch: ...and two of them don't do a lot of office visits. Two of them don't do it. They do rarely any because they're cardiologists and what they do are our stress tests and echoes and such. But when we get paid, we get

paid to the group. So, when they calculate this 10% threshold, is it gonna be based on that group NPI or is it gonna be based on individual doctors.

Michael Rapp: Group NPI is not really relevant to any of the considerations. It's always the individual NPI. The payment is not made to the group - the payment is made to the tax I.D. number, the whole year the tax I.D. number to which the payments for those individual doctors are assigned or re-assigned. So, in your case you're talking about, I'm gonna assume that the two rarely do office visits won't either submit the quality data codes for the electronic prescribing measure or they won't meet the 10% threshold.

The eight who do do office visits, I will assume that they will qualify. So if that's the case, all eight of those would qualify and a determination would be made for each one of them as to what their individual total estimated allowed Part B charges are, and a 2% times that would be calculated, and that payment would be made to the ten along with the payments for all of the other seven cardiologists that qualify or physicians that qualify. But it would be paid to whoever gets the money for that doctor anyway.

Joanne Koch: Right. So it's based on the individual activity, but it's paid the group.

Michael Rapp: Exactly.

Joanne Koch: Okay. Then I thought of another question. The - is there any order? Like, when we did PQRI, is there any order on the claim form that these - does the G code as the numerator has to be the first service on the claim form and then the E&M codes or the office visits have to be

second right directly underneath that or just on the same claim, it doesn't matter what order?

Michael Rapp: I'm gonna have my experts from that end of the house answer the question.

Joanne Koch: Okay.

Pat Gill: This is (unintelligible). I work in the claims processing area here in CMS. No, there's no order into putting, you know, the G codes or the denominator codes on the claims. Mainly what I see, you know, when we look at some claims from our contractors, we normally see the payable services listed first and then - and I'm talking PQRI here - and then the QDCs or the PQRI CPT codes listed second. But, I don't think it matters what order.

Joanne Koch: Okay, because I thought at some point in PQRI that they defined, because it's a numerator, that it would be on top of the denominator codes. But what you're saying is they may have changed that and it's not necessary. It can be in any order as long as it's on the same claim.

Pat Gill: It has to be on the same claim. It doesn't matter what order.

Joanne Koch: Okay, now here's my final one and it's really a comment. We've participated in PQRI for about 100 physicians in various - in 30 different groups. We thought we successfully reported on all of our physicians and not one of them got a bonus payment. Have all the bonus payments been distributed for 2007 and the first half of 2008?

Michael Rapp: Are you familiar with the report on the 2007 PQRI experience that we posted on our Website recently?

Joanne Koch: Yes and we had to involve our clients to contact. It was very cumbersome.

Michael Rapp: So this is - we - last week, December 3 I believe it was, we posted, on the PQRI Website, a rather extensive report on - not individual reports but an aggregate report as a PQRI reporting experience. And what you've just brought up, you had quite a number of doctors reported PQRI and weren't successful in reporting, which is of course distressing to you and distressing to us.

Joanne Koch: And to the docs.

Michael Rapp: And to the doctors of course.

Joanne Koch: Because what that - now they have this, why bother, I don't want to do it, and then like, well, you have to use - you really should do the ePrescribing.

Michael Rapp: You're right.

Joanne Koch: ...already doing it and their reply to me is why. We didn't get our other one and we reported it? We thought we reported it successfully.

Michael Rapp: Okay. Well, I have some news that I think will be good news to you.

Joanne Koch: Okay.

Michael Rapp: And one of them is we did an extensive analysis based on this kind of comment that you just made that the doctors worked hard to report and what do they have to show for it. Some complaints were, we can't

understand the reports. We can't get the reports and when we get the reports, we don't know why we didn't qualify.

So we sought to try to answer those questions and I think if you will download this report, which is again the main PQRI Website. When you get to the first opening page, it'll (unintelligible) to you - it'll tell you about this and down at the bottom, it'll give you a download of this whole report.

Joanne Koch: It's the December 3, 2007 reporting experience?

Michael Rapp: Exactly.

Joanne Koch: Okay, I'll read that.

Michael Rapp: And when you go to that, you're gonna find in the appendix a detailed list by measure of why quality data codes were not validly submitted. The number 1 reason was that the quality data code was submitted for a patient for which the measure didn't apply. That's the number 1 reason. And so, it's important for physicians to look carefully at the quality measures and understand the circumstances if they're reportable, and the circumstances that they're not.

One thing about the electronic prescribing measure is when you read the report, you'll see that some of the issues for 2007 PQRI had to do with diagnosis codes, and specifically that line item diagnosis were looked at rather than all of the diagnoses that might appear on the claim.

So with regard to electronic prescribing, there is no diagnosis code required. It's just only the HCPCS code. So that makes the measure

relatively simple to report. It's 3G codes, it's a very discrete set of office visit codes. Age, gender, and diagnosis are irrelevant, so that's one thing.

The - so, just in terms of what we're gonna do for 2008 and 2007, one of the other things that we heard from doctors was, well, we've gone through the whole 2008, we weren't successful in 2007, whatever we did wrong in 2007 we probably did wrong in 2008, and we won't get a bonus.

So, I've already gone over the NPI issue. The NPI issue affected about 12% of the quality data codes and as I indicated, that is not an issue for 2008. The NPI issue isn't an issue for 2008 or PQRI, nor is it an issue - will be an issue for 2009 as indicated. For 2007, it was an issue in terms of the claims were processed, but the PQRI didn't count unless there was an NPI. So about 12% of the quality data codes didn't have an NPI, didn't count, and that did impact successful reporting.

But in addition, things that - we found some technical corrections that we could make for 2008, even though they were business rules that were set forth such as the line item diagnosis, and also that the quality data code be on the same claim, we found that in some instances, the clearing houses were splitting the claims.

So, basically what we've come down to is we have some technical corrections that we could make that we believe will increase the success in valid quality data code reporting, and correspondingly increase the percentage of successful qualification for the bonus for those physicians. And so we expect that to be increased for 2008.

And the other good news I think for you is this, that we can apply those same analytics for 2007 and we're going to do that. And at the same time that we do the calculation and payment determination for 2008, we're gonna go back and rerun this or the doctors that didn't qualify for a bonus. So if you say you had 100 doctors that submitted quality data codes for PQRI in 2007 and none of them qualified, we're gonna go back and look at theirs all over again and in doing that, we're gonna make a couple modifications.

One, we're going to look at any diagnosis on - that was on the claim and you'll see that quite a number of quality data codes, about 13% were disqualified because it didn't have the right diagnosis. And we think that a lot times that diagnosis was there, but since we only looked at the line item, we didn't see it.

Joanne Koch: Right.

Michael Rapp: That will be one thing. And then the split claims where clearing houses and perhaps electronic and interface software split the claim somehow, we are gonna try to bring those back together and in many instances, we'll be able to based upon the same date of service for the quality data code as for the other service. Now if the physician really did only put a quality data code on claim and didn't put it all on the claim, then we can't bring it back together obviously.

Joanne Koch: Right.

Michael Rapp: Because there's nothing to bring back together, but where we can we'll do that, and that will increase the percentage of cases of valid quality data code submission.

So in short, I think you'll find the report quite illuminating. It was a program that had to be implemented in six months based upon a claim system that was not designed for quality data reporting, but we had to take that as we found it, based upon rapidly developed measures by professional societies, some of which were quite complex and led to difficulties in reporting. So a lot of those that - actually from 2007 went away for 2008 weren't included because they didn't work very well or didn't receive endorsement.

So, in short, we're gonna give it another go for 2007 and apply the same modified analytics that we're gonna apply for 2008. In each case, it should increase the percentage of doctors that qualify the incentive payment.

And none of these issues should be real issues for the incentive - few of these issues should be really applicable or really none for the electronic prescribing incentive program, mainly because the measure is so basic in terms of only having HCPCS billing codes in the denominator, that the NPI issues is gone, and these other issues except for the split claim - but the split claim, if they're split and we can bring them back together, we'll bring them back together.

So, hopefully that's good news to you and...

Joanne Koch: Yes, it is very good news (unintelligible) and I'll let you go. I have one final question.

Natalie Highsmith: No, I'm sorry Joanne, We must move on to our other people who are in the queue to ask questions. If you like, you could get back in, but we need to press - move on. I do apologize.

Joanne Koch: All righty, thank you.

Natalie Highsmith: Next question please.

Operator: Thank you. The next question is from George Galev from New Hampshire. Galev, your line is now open.

George Galev: Hi, this is George Galev at the Memorial Hospital. We have a critical access hospital base practice and my question is whether or not we can participate if we're using a UB form versus a 1500 form?

Michael Rapp: No. We don't have the ability to accept the information that way, but hopefully we'll be able to work through this issue perhaps in the next year. We understand that's an issue. You have to bill through the normal Part B 1500 form.

George Galev: Okay, thank you.

Michael Rapp: You're welcome.

Operator: Thank you. The next question's from Bruce Wilkinson from Missouri. Your line is now open.

Bruce Wilkinson: Thank you. Bruce Wilkinson from Missouri, CVS Caremark. My question's regarding the script standard. One of the questions that we've been discussing internally is today, we support (unintelligible) transactions, but do we need to support also the prescription change and response, and prescription cancellation and response? Because right now in the industry, we (unintelligible) the physician deny (unintelligible) new prescription instead.

Michael Rapp: We're talking about the Part D standards here.

Bruce Wilkinson: Yes.

Michael Rapp: You're asking whether or not those - how those standards relate to the Part D (unintelligible).

Drew Morgan: If the script standard in 2005 we listed a whole bunch of functionalities that were - that it supported, and if we had listed those functionalities, then those must be supported by the plan. Now 8.1 - we're adopting 8.1 as of April 1 which has a couple other functionalities. One of them is the (ARPS) fill so I mean, you have to go back and look at (unintelligible) rules and look at what we had listed out as functionalities for those script standards and that's what we expect plans to support.

Bruce Wilkinson: So it's safe to say that eventually that - if you're stating the standards and it's requirements versus these are the ones you must use if you're gonna use it.

Drew Morgan: Right.

Bruce Wilkinson: Thank you.

Operator: Thank you. The next question is from Pamela Ballou Nelson from Illinois. Your line is now open.

Pamela Ballou Nelson: Thank you. It's Pam Nelson from Ad Dentist Health Network (unintelligible). I think you may have already answered my question, but let me just be sure I understand it correctly.

If a patient comes into the doctor's office and let's say is given a sample for a dermatology condition to see if it works or not, then it works and calls back the physician who then has a qualifying ePrescribing system and everything else is in place. Then that prescription really cannot count because from what I hear, is that the patient must be in the office and the prescriptions ordered at the time the patient is in the office. So refills or samples and then callbacks are not counted, is that correct?

Daniel Green: Refills would not be counted because there's no office visit that would be associated with that. I mean, the only way the example that you described could be counted is if the provider held their claim, which of course they're not gonna do, to later add the G code that I did e-prescribe.

So for all intents and purposes, if they give a sample and don't give the patient anything else and the patient calls back let's say a week later and says oh yeah, it's working great for me and then the provider either writes, picks up a phone or whatever, again there is no visit associated with that phone call so there would really be nothing for them to report.

Now, in the first visit of course, they would have to report that basically no prescriptions were generated because again, they haven't written anything, they haven't called anything in to a pharmacy, they're just giving a sample and they're trying out a medication if you will.

Pamela Ballou Nelson: Maybe the trick - (unintelligible) what we need to do then is be sure we give them a prescription at the time we give them the sample to go ahead and use, and if they need it, then we can count it. Would that be correct?

Michael Rapp: No, let's be clear about what - how this works. The occasion to report is when you bill one of the codes in the denominator. So we don't want you to do something you wouldn't otherwise do. You're just to report what you did do. So, let's say it's an office visit. You're dermatology practice did you say?

Pamela Ballou Nelson: Well, we have lots of different practices, but that's one example that came up in a meeting today.

Michael Rapp: Okay, let's say it's a dermatologist and so the patient comes in. You're ready to bill the visit and what happened at the visit is the doctor gave him a sample. Well there - and now the doctor has an electronic prescribing system. There are three possible codes to report to qualify as reporting on an applicable case; you could report that no prescriptions were generated, that all prescriptions were e-prescribed, or that some or all of the prescriptions generated were not e-prescribed for the valid reason.

So in this case, one gave a sample. There was no prescription. One would report that no prescriptions were generated during the visit. That is perfectly acceptable for reporting. There is no requirement that one prescribe when they wouldn't otherwise prescribe or e-prescribe necessarily.

But if you don't e-prescribe and you don't have one of those good reasons, and you have prescribed at the event then you just wouldn't report anything at that. If you are the situation that Dan said where you just don't feel like doing it that day, that would be a non-reportable event. But you don't have to prescribe something when you wouldn't

otherwise prescribe. You just send - put in the G code that you didn't prescribe at that visit.

Daniel Green: And so you still get credit for reporting, and again, as we've said on the call, you need to report on at least 50% of eligible patients. So you still count as one of your 50% - as going towards your 50% even if you didn't prescribe anything.

Pamela Ballou Nelson: Okay.

Michael Rapp: It's just reporting the G codes that is what determines whether or not one qualifies for the incentive. It's not how many times you e-prescribe or how many times you even prescribe.

Pamela Ballou Nelson: Okay, all right. Thank you very much.

Daniel Green: Thank you.

Operator: Thank you. The next question's from Alice Chan from Florida. Your line is now open.

Alice Chan: Hi, my name is Alice Chan. I'm calling from Memorial Health Care in Florida. And I believe that my question was answered earlier regarding the hospitalists, and it's just clarification that for at least 2009, their Medicare Part B billing would not meet the requirements for the financial incentive, is that correct?

Michael Rapp: Well, of course it depends on what specific codes are billed for that particular practitioner. So when we say a hospitalist and say they wouldn't be eligible, and I'm going to assume that less than 10% of their total Part B allowed charges are related to the codes and the

denominator and the measure. If that's the case, then correct. They wouldn't be - they would not be eligible for the incentive.

But, it'll depend on the specific codes used to bill for that particular doctor's services and in many instances, they may be hospitalists but they may end up seeing patients in some other aspect of the hospital setting for which those codes are bills, which could add up possibly to 10%. So, I hate to categorize people or physicians on the basis of what their category is, because it may not be accurate.

Alice Chan: Now, are there any plans in the future to include, you know, services that are really hospital related if they do have a qualified system?

Michael Rapp: Well, the measure specifications are subject to revision. The Secretary does have the authority to do that; however, at this point, I would not expect revisions to take place for 2009. That was discussed in the physician fee schedule rule in terms of the focus on a professional office. However, they are subject to revisions.

One could make comments, the final rules, physician feel schedule rule is publishes so if members of the public believe that modifications to the measure could be - should be made, it would be open to comment. And in addition, the measure would be further considered by - through endorsement processes and that would be another vehicle to make such suggestions.

Alice Chan: Great, thank you.

Operator: Thank you. The next question's from Kerry Gasperson from South Carolina. Your line is now open.

Kerry Gasperson: Hi. Again, this is Kerry Gasperson in South Carolina with University Medical Associates. And this kind of gets at the same question that was asked about the hospitalist, and I hate to be redundant, but I want to get very - a very clear answer on this. It - I was interpreting the section where they discuss expanding the scope of the denominator codes to professional services outside of the professional office and outpatient setting for 2009, such as professional services furnished in hospitals or skilled nursing facilities.

We have a great number of physicians who practice in the outpatient hospital setting and as I've been listening, it seems like the limitation is more the list of codes rather than the place of service. Is that correct?

Michael Rapp: That is correct. It is not the place of service specifically. It's just that these codes are codes that are generally in the professional office, but it doesn't have to be that - it's not a place of service.

Kerry Gasperson: Okay, because it - in the justification, there are four reasons citing - cited for maintaining the denominator list as it is. One is the limited ability of physicians or other eligible professionals to implement fee adoption and availability of electronic prescribing systems in hospitals. So the way that I thought about that is that if the physicians are working in an outpatient hospital setting, they have the same limitation.

Therefore, physicians who are working in an outpatient hospital setting - the justification is they can't reward them with 2% because they couldn't take the money away, you know, as it - as we move through the years because they didn't have the ability to control that, because it was up to the hospital. So, can you kind of see where I'm coming from here?

((Crosstalk))

Kerry Gasperson: How can the incentivize outpatient hospital when at the same time they're saying that they can't punish people in the outpatient hospital setting?

Michael Rapp: Well, I think - I don't really have anything to add to what's in the rule. You're suggesting that you have some I guess comment on the distinction that was made and the rational for that approach. So if you have that, then you could send in comments to that affect.

But in terms of just how this works, these are professional codes in general, but not exclusively are used in the physician - professional office setting. In some cases, they may be billed by physicians who are practicing somehow in a possibly a hospital outpatient department or something of that sort...

((Crosstalk))

Kerry Gasperson: We have a - you know, a majority of our services are provided in an outpatient - of our outpatient, you know, services, our outpatient hospital place of service, so we're dependent on the hospital to provide that infrastructure for ePrescribing.

Michael Rapp: So are you saying that you would like it further limited by place of service?

Kerry Gasperson: I'm not saying that I would like it. I just - I'm responsible for a thing whether or not this is something that we should pursue or should not pursue. And based on how I've put the pieces together in the rule, it

seemed like it was a place of service limitation because of the justification that - it says the statutory limitation that applies to eligibility for the incentive also applies to the future differential payment provision.

Extension of the denominator codes to hospital-based setting of care may cause professionals to exclusively practice in such settings to be liable for a differential payment for services furnished in the setting where they have limited ability to influence the adoption of electronic prescribing.

So, I mean, I see both sides of it and I'm just wanting to know specifically. At this point, there's no limitation on place of service, the denominator is solely determined by the set of codes.

Michael Rapp: That's correct.

Kerry Gasperson: Okay. Do you see where there's sort of an issue with how the justification supports that.

Michael Rapp: Well, I hear that you have some comments about the justification, which again, if you would like to send those in a formal way, you can do that and they would be considered. I don't have any real response to it. It's just that if you would like to make those comments, I would invite you to do that.

Kerry Gasperson: Okay, thank you very much.

Operator: Thank you. The next question's from Karen Deaner from New Jersey. Your line is now open.

Karen Deaner: Hi. My name is Karen Deaner. I'm from Adult Medical Oncology in New Jersey. I know this is redundant also, but with regard to the 10% eligibility, I represent and Oncology practice and in every visit that utilizes the reporting denominator, if a patient receives chemotherapy, the allowable charges will be greater than 90% of the total charges every time.

Michael Rapp: Okay. Let me just stop you there.

Karen Deaner: Okay.

Michael Rapp: It has nothing to do with Part B drugs.

Karen Deaner: Okay. Then...

Michael Rapp: It's for professional services.

Karen Deaner: Perfect. Then consider it dropped. And I have one very quick question. If they are going back and looking at the 2007 PQRI, I was under the impression that if you used the evaluation and management code and you used the proper measure, that didn't have to have the diagnosis code, but the PQRI measure had to have the proper diagnosis code. Is that correct? Am I making myself clear?

Michael Rapp: Not exactly. The...

Karen Deaner: Let's say - I'll be very specific. Let's say there was a measure for breast cancer, a specific kind of breast cancer. But your patient had an evaluation in management code that day and you would use, if they were there for any other reason, heart burn, let's just say, or

constipation and used that diagnosis code. But then you used the PQRI measure with the breast cancer code.

Michael Rapp: You're saying you don't have the breast cancer code anywhere on the claim?

Karen Deaner: Yes, on the claim in the PQRI measure, but not in just what eludes to the evaluation in management.

Michael Rapp: You're saying you didn't use the diagnosis pointer you used for the EMN - the (Hickpix) code, you pointed to heartburn./

Karen Deaner: Yes.

Michael Rapp: It didn't point to breast cancer.

Karen Deaner: Correct.

Michael Rapp: But you had breast cancer on the base claim.

Karen Deaner: Correct.

Michael Rapp: So what I'm saying is that the NM code and what you pointed to for that doesn't make any - didn't make any difference.

Karen Deaner: Okay, I was just looking for a reason why I didn't make the...

Michael Rapp: Yeah, but you had to point to the - or the - for the CPT2 code that you put in, you did have to point to breast cancer.

Karen Deaner: Correct, and I did.

Michael Rapp: If you pointed to heartburn, then it wouldn't have counted.

Karen Deaner: Correct. No, I understand that. I was just looking for a reason why we didn't make the measure.

Michael Rapp: Well, maybe they'll be a reason. It could be a split claim issue or something of that sort. So, you may - did you qualify for the bonus?

Karen Deaner: No.

Michael Rapp: Okay, so we'll rerun that and possibly they'll be reasons that we find that the physician involved will qualify.

Karen Deaner: I hope so. Do you know when we might hear about that?

Michael Rapp: Well, you're not gonna hear that - about that soon. What the result of us modifying these analytics will involve an additional three months time, so we had expected to get the bonus payments out in July, so it'll be a time now it'll be more like October. It would be in October of '09 and you'll get the 2008 payment. You'll get the 2007 payment if there's one. We're gonna consider all the physicians that didn't qualify and you'll get a more detailed and understandable report.

I would also invite you to look at the specifics of the report I mentioned to you..

Karen Deaner: Yeah, you started to and then the woman who (unintelligible) she knew the report that would kind of stop there so if you could just repeat that.

Michael Rapp: Yeah, well let me tell you about it. There is an appendix in there, which has every measure that is listed in - every measure that was for 2008 so you had - you were talking about a breast cancer diagnosis. So for example, let me see. The colon - can't find the breast...

Karen Deaner: It was either 71 or 72.

Michael Rapp: Seventy-two, okay. Seventy-two is chemotherapy for stage 3, I think, colon cancer. But - yeah, I can't...

Karen Deaner: That's fine also.

Michael Rapp: But it - but let's just do the chemotherapy for - so in that case, you'll see information like this, 56% of the quality data codes there were valid and the reasons for invalidity of that one, 21% was age. So this has an age parameter. There's no technical issue with that, but that's just knowing the measure. An incorrect (Hickpix) code on that was 7.8%, so that's where the wrong billing code was on there, but that's very - relatively low on that. Incorrect diagnosis for that was 12%, so this multiple diagnosis and pointer issue could have been affected there. And, the split - the only quality data code was only 1% on that measure, so the split claim issue didn't affect that.

So, for each measure, you will be able to go through and see what the errors were and why that - quality data codes weren't accepted.

Karen Deaner: Right, but not specific to yourself, just in general.

Michael Rapp: Yes. But although it's not specific to yourself, I think it'll be quite informative because you'll be able to see, I wonder if that affected me. But you will get a report next year on 2007 at this detailed level for

yourself so it'll be later than of course you would like, and you'll get it regardless of whether you get the payment.

Karen Deaner: Okay. I did get the report from the IX system but I found that equally as confusing. It didn't help me out at all.

Michael Rapp: That's because it wasn't detailed in terms of invalid reporting like this, but it - the next year will be.

Karen Deaner: Okay. Thank you for your help.

Michael Rapp: You're welcome.

Operator: Thank you. The next question's from Phil Burgess from Illinois. Your line is now open.

Phil Burgess: This is Phil Burgess. I'm with Walgreens and Chairman of the Illinois State Board of Pharmacy. I have a policy question if I could, quickly. As I'm sure you're aware, the cost control drugs can't be submitted electronically. There's a significant resistance from physicians to utilize two systems when they're attempting to prescribe for a patient, and one or two prescriptions is for a controlled drug, and one or two are for not a controlled drug. And I'm curious whether CMS is working with DEA to urge them to expedite their approval of controlled drug, electronic prescriptions, and specifically, is there anyone within CMS whose responsibility that is?

Drew Morgan: That would be me. I'm actually on one of the workgroups that work with...

Phil Burgess: I'm sorry, me is who?

Drew Morgan: This is Drew Morgan. I am currently (unintelligible) Department of Health and Human Services as a team that's been working very closely with the DEA over the last couple - last month or so going through the public comments that came in on the DEA proposed rule. And we are working very diligently trying to meet the DEA requirements that they need for diversion and fraud and at the same time, a rule that we feel that would not be overly burdensome to industry. So, yeah, we are working on it right now.

Phil Burgess: But I think you're aware that some people do view it as overly burdensome as you say. Are you trying - guys trying to kind of loosen that or trying to work with them to make it more amenable to the industry?

Drew Morgan: Well, we're working with the DEA. We were - looked at the comments that pharmacy - that industry has put in on their proposed rule. They have - I really can't go into what they have decided, but some of the things that they had proposed they have taken off the table. Some other things we're still working through. But, I, you know, I don't - I couldn't really give you a timetable of when the final rule will go out whether it be a final rule with comment or (unintelligible) just let you know that we are working with them.

Phil Burgess: I just would like, you know, say we appreciate your efforts and support on that.

Natalie Highsmith: Next question.

Operator: Thank you. The next question is from Linda Maas from South Dakota. Your line is now pen.

Linda Maas: Hi. I just wanted to encourage you towards your work in certified rural clinics. We're from Avera St. Benedict, a certified rural health clinic in South Dakota, and we're certainly interested in the incentive program, and we're ready to go whenever you are. Thanks.

Michael Rapp: Thank you for that comment. We are working on it.

Operator: Thank you. The next question is from Tom Reinecke from Iowa. Your line is now open.

Tom Reinecke: Hey, this is Tom from Dubuque. We have an EHR product that gathers insurance information at the time the patient presents at registration and then we load the formulary data from a third party. We're wondering if that qualifies for item number four, patient eligibility.

Michael Green: Well, maybe. It would be dependent on whether or not your - the information that you load not only has the formulary, but any authorization requirements. So if you were prescribing a high-cost medication so that signaled that oh, preauthorization is required for this drug, you know, with the formulary information that you're loading.

Tom Reinecke: It does provide preauthorization, if that's needed.

Daniel Green: Okay. And then the other issues of course would be that you still need to be able to communicate with the pharmacies and the pharmacy benefit managers to be able to generate a complete and active medication list.

Tom Reinecke: (Unintelligible).

Daniel Green: As well as conducting the safety checks that are defined in the measure.

Tom Reinecke: Right, understand all of that. Yeah, so we do the safety checks and the measure.

Daniel Green: And you do the incorporation of data to generate the medication list?

Tom Reinecke: Well, that's the part we believe we have to add in that we have a medication list in the HR but obviously, it's not gathered from the PBM. You're saying it's a requirement to get that from the PBM?

Daniel Green: It is, and you can imagine that they're patients out there that forget, oh, you know, hey, I (unintelligible) orthopedic surgeon last week for my back pain and they started me on (Amerdral) dose pack and I'm only on it for six or seven days and you know, so they forget to - excuse me - mention that to the provider that they're seeing. So, while an EHR is wonderful, it doesn't take the place of gathering the data.

Look no one system is gonna be perfect. I mean, you know, someone emailed me today that a patient could be taking an over-the-counter drug and that's not gonna be obtained from the PBM. (Unintelligible) so you really need to join the EHR if you have one.

The patient history that you're updating when you see the patient face to face, as well as the information from the PBM from a quality standpoint and a safety standpoint. But as for meeting the measure, it is required that you get that information or have the ability anyway to get that information electronically from the pharmacy and PBM if it's available.

Tom Reinecke: When you bring in that data electronically the medication history electronically do we have to do our interactions against that or can we just present that data to the physician?

Daniel Green: Well, we're not in any way telling any provider what they should or shouldn't prescribe for a patient. I mean, I'm sure you're aware of circumstances that it may be off labeling use for a particular medication or despite a possible interaction, it may be the only drug that's suitable for that particular condition. So, we're not trying to tell the provider what he or she shouldn't prescribe. But it alerts me to come up and at least make them aware of it.

Tom Reinecke: Yeah, so the alerts do have to go against that med history then you're saying.

Daniel Green: Yes.

Tom Reinecke: Okay. All right, just verifying. Thank you.

Daniel Green: Thank you.

Operator: Thank you. Our next question is from Lori Lazouras from Rhode Island. Your line is now open.

Lori Lazouras: Yes, hello. I represent University Medicine Foundation. We are a practice of approximately 140 plus physicians and I think I finally have a question for you that's quite different than everyone else's.

What I have is a situation on three physicians who participate in the PQRI. Only one met the measure, and I'm thinking from what I'm

hearing on the - this conversation today and previous calls that I've listen in on that you may have resolved what the issue might be, and I'm anxious to see what is forthcoming in the next year.

But, I had an instance where my PQRI money that was paid to the one physician who met the measure actually had a take back out of the PQRI money that represented another physician in our group who never participated, and it represented a Medicare claim for a take back of money for a claim issue.

And I have yet to be able to get this resolved. It's not a lot of money, but it still came out of his full incentive and we can't seem to get much help from our local Medicare reps because we're kind of throwing them for a loop too. Have you heard this happen before?

Pat Gill: It - are you saying that as part of the group, there was some type of offset?

Lori Lazouras: Yes.

Pat Gill: And if that offset was for that group's NPI, then that's why you didn't get the whole PQRI check if the group - if the Medicare contractor needed to recover some money.

Lori Lazouras: But why did it come out of - why didn't it come out of our (unintelligible) settlement rather than the PQRI money. This physician never entered the measure at all. He didn't even participate.

Pat Gill: But since the bonus check is paid to the first NPI for that ten, which in this case appears to be the group, and that group had an offset, it can be held from that money.

Michael Rapp: If the payment go - I'm not in this area but the payment for the PQRI goes to the group or the tax I.D. number, so it's the individual physician reassigns their benefits to the group so the group gets the money. So...

Lori Lazouras: But the check was made out to him, which was also ironic, to the physician who did not participate.

Pat Gill: The bonus check?

Lori Lazouras: Yes.

Michael Rapp: Is that the person who has - to whom the benefits are reassigned?

Lori Lazouras: No. There was - whom the take back was on.

Pat Gill: Can I get your name and number and have a conversation with you offline. What contractor are you billing?

Lori Lazouras: Through Arkansas.

Pat Gill: Okay.

Lori Lazouras: Pinnacle.

Pat Gill: Okay. Can I get your name?

Lori Lazouras: Yes. Lori Lazouras.

Pat Gill: Okay, and...

Lori Lazouras: And my direct phone number is 401-784-4934.

Pat Gill: Let me repeat the number, 401-784-4984?

Lori Lazouras: No, 4934.

Pat Gill: 4934, okay. I will give you a call and we can talk about this issue.

Lori Lazouras: And your name?

Pat Gill: (Pat Gill).

Lori Lazouras: Thank you very much. We'd really appreciate that.

Natalie Highsmith: Okay (Amanda), I think we have time for one final quick question.

Operator: Okay. The last question comes from Jessica Stemple from New Jersey.

Jessica Stemple: Hi. I'm from a pharmacy, an independent pharmacy in Atlantic City, New Jersey and we're concerned about how is this going to affect us. How am I going to know as a pharmacy that the prescription has - that the prescriber has the correct software that's Medicare acceptable when I'm accepting these e-scripts?

And my second little part of the question is this isn't gonna change any kind of hard copy requirements for test strips or nebulizers or Medicare part B transplant patient script requirements, correct?

Drew Morgan: As an independent pharmacy, are you certified on the SureScripts network, your software?

Jessica Stemple: It will only be SureScripts that we can accept.

Drew Morgan: Well they - currently, they are the network that handles these electronic prescription. They (unintelligible) speak of from the physician to the pharmacy.

Jessica Stemple: Okay. Now I do believe that we have that right now, but we can also accept scripts from a couple other different sources as well.

Drew Morgan Right. And it you aren't script enabled and are not, you know, able to accept electronic prescriptions into your software system, SureScripts then converts that file into a fax and it gets sent to the pharmacy.

Jessica Stemple: No, we definitely already convert into scripts, so anything that already converts into my system is fine and I'm allowed to use that as a Medicare Part D billing prescription?

Drew Morgan: Right.

Jessica Stemple: Okay, and then what about hard copies for things like test strips and nebulizer solutions? Are they allowed to be e-scribed or are they still excluded from ePrescribing requirements?

Drew Morgan: We - any drug - any prescription drug that is on a Part D formulary is eligible to be e-prescribed.

Jessica Stemple: Okay.

Drew Morgan: So let's...

Jessica Stemple: Well, what I'm talking about is more like, you know, the handwritten requirement with diagnosis codes from the physician. So they would be excluded from the ePrescribing? I would still have to have a hard copy, handwritten prescription with diagnosis codes?

Drew Morgan: (Unintelligible) answers that right now. I can certainly get back with you.

Jessica Stemple: Okay. Do you need the phone number?

Drew Morgan: Sure.

Jessica Stemple: It's 609-345-5105.

Drew Morgan: What is your name again?

Jessica Stemple: Jessica.

Drew Morgan: (Unintelligible) Jessica.

Jessica Stemple: Okay.

Michael Rapp: Thank you Jessica.

Natalie Highsmith: Okay (Amanda). We have passed our 5:00 hour here on the east coast. I will now turn the call over to Dr. Green or Dr. Rapp or Drew Morgan if they have any closing remarks.

Michael Rapp: Well, I just want to thank all of the callers who joined us. It's helpful to hear the questions, have an opportunity to respond to them, and I am grateful for everyone who joined the call. As far as the next national

provider call we have on a related subject, the physician quality reporting initiative, we have that scheduled on the 16th of December.

Those of you on this call probably got a notice about that, so we'll be continuing to discuss the PQRI. I'm sure we'll get some questions on the electronic prescribing incentive program as well, but the main focus of that will be PQRI.

So again, thank you for joining and thank you for the questions.

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

Operator: Three hundred and sixty.

Natalie Highsmith: Three sixty. Everyone, I just wanted to give out the email address for your questions. It is e.prescribing@cms.hhs.gov - E as in electronic, dot prescribing at C-M-S dot H-H-S dot G-O-V. Thank you and have a great holiday.

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

END