CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:

2008 Physician Quality Reporting Initiative – Participation by the American Academy of Ophthalmology

Moderator: Natalie Highsmith
August 14, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Jennifer) 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 on 2008 PQRI participation by American Academy of Ophthalmology Open Door Forum.

All lines have been placed on mute to prevent any background noise.

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

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

Natalie Highsmith: Thank you (Jennifer). And good day to everyone and thank you for joining us for this Special Open Door Forum participated by the American Academy of Ophthalmology.

We are hosting this open door today to encourage PQRI participation and provide you with simply steps to collect and report quality data to be eligible for an incentive payment from CMS.

The agenda has been posted on the Special Open Door Forum web page at www.cms.hhs.gov/opendoorforums with an S and on the left hand side you will see a link saying Special Open Door Forums and you will see the agenda under the download section.

The slides for today's presentations have been posted on the American Academy of Ophthalmology web page at www.aao.org/advocacy.

I will turn the call over to Dr. Daniel Green who is the Medical Officer and the Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality.

Dr. Green.

Daniel Green: Thank you Natalie. I would like to welcome everyone to today's call. We appreciate the opportunity to speak with the members of the American Academy of Ophthalmology.

Today our presentation, unfortunately Dr. Rapp was unable to join the call today so I will be acting in his - on his behalf.

And we also have Dr. Bill Rich from the American Academy as well as Dr. Kirk Winward who were kind enough to participate in today's call.

And in addition we also have (Sue Visherelli) who will also help facilitate today's call.

So without further ado I'm going to turn the call over to Dr. Rich.

William Rich: Hello. Again I'd like to thank CMS for our collaboration on educating the members.

Basically we have several topics that we're going to get into. We're going to talk about preparing for participation in 2009, what to expect, what's going to happen with some new pilot measures that may be available in '09 but we won't know until November.

We basically have a PQRI update of what's really going on now and we're also going to then get into a question and answer period.

First I'm going to turn it back to Dr. Green to talk about some of the reasons why we should consider participation in PQRI in '09.

Our specialty has been intimately involved in quality metrics. We're the first one to actually develop evidence-based processes of care in 1985 so we've been at this a long time.

And we were actually one of the specialties with the three highest participation rate and I think it's important that our members understand that PQRI is not going to go away. More and more patients are concerned about

the quality of the services that they're purchasing. People are paying more out-of-pocket not necessarily Medicare but in the commercial world.

So the idea that these - that this emphasis on quality of care and reporting on quality of care and public disclosure of your participation rates, if anyone thinks its going to go away I don't think that's really practical.

So I think it's important we continue to educate the members and broaden the participation.

Dr. Green.

Daniel Green: Thank you. Yes, I'd just like to echo your sentiments. First of all we certainly appreciate the efforts that have been extended on the part of the ophthalmologists. As you mentioned they were one of the three highest reporting specialties that did submit quality data through PQRI.

So we do really appreciate everyone's interest and involvement and we would ask you to encourage your colleagues to join you and also report quality measures data.

We think that it's important to participate in PQRI because the type of measurement reporting should be part of everyone's overall quality improvement strategy.

As it's currently designed PQRI is a relatively low hurdle. The only additional work is putting three extra codes on some of the Medicare bills.

So it's an easy way to let CMS know that you are actually providing the kind of care that your patients expect from you.

At the same time much of this care is, as I mentioned is probably already being provided. However there are some instances where it may actually remind you that hey maybe I should do this particular test on this patient or recommend this particular medication or diet or what have you for this - for a special patient.

So we hope that at the same time it will also prompt and actually improve the quality of care that the patients do receive.

We think that it can provide valuable learning about your ability to provide high quality care to your patients hopefully through the feedback reports and some of the lessons that - you'll learn some lessons to improve the quality of care that your patients in fact do receive.

And finally of course there is the financial reward for undertaking this and the Congress in the MIPPA legislation which was passed in the end of July actually did make PQRI a permanent program and in addition authorized payment for 2009 and 2010.

The 1.5% bonus that is PQRI currently pays to successful providers that report will actually increase to 2% for 2009 and for 2010. There is no authorization for beyond 2010 in terms of incentive payment though we do feel that Congress will likely continue along that road and fund this in the future for 2011 and beyond.

So having said that we do think PQRI is becoming a permanent program and we've seen that even other payers are starting to move in this type of direction.

So having said that Bill did you want to add anything or Kirk before we move onto the new measures?

William Rich: Well I think one of the things that those of us have participated in and should emphasize to our colleagues is, and to the administrators on the phone, that this was actually quite simply administrative to begin.

My group is a little atypical. We have ten ophthalmologists with a mix of subspecialties.

It really took us literally five minutes to modify our fee schedule bill to add the applicable PQRI codes both for ’07 and ’08. And I think that there was a lot of scared language out there that’s just going to be an administrative nightmare.

And frankly and Kirk you may want to comment, it was really quite easy to implement in a large practice with many diverse types of sub-specialists.

Kirk Winward: That was our experience as well. And I have a few other things that I am planning to say but I will hold off on those until I discuss the new retina code.

William Rich: All right.

Daniel Green: Thank you. Thank you for those valuable comments.

We are - we realize its quite a bit of - there’s quite a bit of material out there to read about PQRI and we are striving to condense that and make it - make the, I guess the instructions if you will a little bit easier for folks to digest and to implement because we realize everyone - all the requirements practitioners

face in their practice and they're being pulled in 50 different directions at once.

So we are trying to make it a little bit easier. We've come out with a PQRI made simple which is really geared a little bit more toward primary care docs that want to report the preventive care measure group.

But we are working on made simple tools if you will for the E-prescribing initiative that you'll hear more about later and in subsequent months and reporting groups in general.

So we hope it'll make it even simpler for providers to participate.

I'm going to just dive into the new test measures that we have on our web site. There are three measures that apply to ophthalmology.

The first one is listed as test measure T139 and it basically is - has to do with cataracts and comprehensive preoperative assessment for cataract surgery with intraocular lens placement.

Our test measure 140 has to do with age-related macular degeneration and this is counseling on antioxidant supplement.

And then test measure 141 has to do with primary open angle glaucoma and this would be a reduction of intraocular pressure by 15% or documentation of a plan of care.

And these three measures are currently available for reporting in 2008 however there is no incentive payment attached with them. Excuse me. We

are doing some pilot testing to see how the measures work and how successful folks are at reporting them. They are also in our 2009 proposed rule.

However there's been no decision regarding the inclusion or exclusion of any measures for 2009 and unfortunately we're not able to discuss that today because we're in the midst of our rule making and the comment period doesn't close until the end of August.

So if folks do have favorable or unfavorable comments about these measures we would encourage them to submit those comments so that we can respond to them in the final rule and consider them when the final rule is actually put together.

So I'm going to turn the call back over back I guess to you Rich. I think you're up next.

William Rich: Yeah.

Daniel Green: Dr. Rich, I'm sorry.

William Rich: That's okay. I also answer to any name.

I'd like to discuss the cataract one. And I think what we're going to see in the profession is a move away from kind of the simpler measures we had in '07 to more robust measures that are more meaningful for patients.

And indeed the cataract measure that's going - that hopefully will be available in '09 basically asks you for eligible patients to make sure that a dilated fundus examination is done, obviously an actual length measurement is done,

and most - and the new wrinkle here is a statement of the functional medical indications for the surgery.

In other words just because a patient has a certain level of vision we should be able to document or we must document how that affects the patient's lifestyle.

These things are to be reported each time cataract surgery is done with an IOL.

And it's anticipated that the operating surgeon, the clinician who performs the surgery will submit this measure.

And the new code for this is like all CPT codes. There are basically three types.

Category I that's your EM services your cataract code.

Category III is new technology codes.

But Category II codes are performance measure codes.

And so the new code for this cataract is 0014F.

And basically you're asked to report on this every time you do a cataract with an IOL.

If for some reason, as you know there's modifiers for exclusion. Patient refused. Kind of hard to see how that would be applicable here. The system wouldn't pay for it, that's another modifier that you could apply.

But so I would actually anticipate that there - I can't imagine that there would be an instance in which one of the modifiers to state that the measure was not performed would be applicable.

The diagnosis codes for the diagnose, for the thing, or the three cataract CPT codes that involve the placemen to an intraocular lens.

So I think this measure is actually pretty straight ahead and a lot less complex than the glaucoma measure that'll be talked about soon a little bit later on.

But again I think this reflects a move to more robust measures. We've also developed a measure for - that's not going to be considered but to give you an idea of what may be down the pipeline in the future is an outcomes measure. How many people see 20/40 with exclusions?

But that's not really germane to our conversation today.

But I think that this measure, the glaucoma measure, really gives you a hint that the patients and the payers are looking for more robust meaningful measures down the road.

Kirk, do you want to get into the macular degeneration code?

Kirk Winward: Okay, thank you Bill. So I will - for those of you that are following the slides I am now on Slide 12.

And I will pretty much follow the slides and I'll somewhat read those for those who may not have the slides right in front of them.

I might just mention that I'm a retina specialist in a five physician retina only practice.

And so the new measure that's being added or that's being considered to add for ophthalmology or more specifically the retina aspect is number T140 age-related macular degeneration counseling on antioxidant supplementation.

And the more precise description, I'm now on Slide 13, is the percentage of patients age 50 years and older with the diagnosis of AMD or their caregivers who are counseled within the 12 month period on the benefits of risks of the AREDS antioxidant formulation, vitamin formulation.

Now those of you who participated in PQRI in previous years will notice that this is very similar to a measure that was used in 2007 and then deleted for the current year.

And I can only speculate why it was deleted and then somewhat proposed to be added on in 2009.

But the main difference is that the 2007 code required that AREDS vitamins were prescribed or recommended and the proposed 2009 code says counseled.

Now to Slide Number 14, the specific instructions are the measure would be reported a minimum of once per reporting period which would be the year. It's anticipated that the clinicians who provide the primary management, the AMD management, would be the physicians who would submit the measure.

And that if another physician is seeing the patient and uses the same diagnostic code then they might use that as a system reason exclusion which I'll discuss in just a second.

So now to Slide Number 15, the code, the CPT code, II code will be 4177F and there are two modifiers. The 3P modifier that would be used to report a system reason for not counseling the patient such as what was just mentioned previously that you might not be the primary or clinician providing the primary management of the AMD or an 8P modifier which says the AREDS counseling was not performed for an otherwise unspecified reason.

On Slide 16 the CPT codes to which the measure applies are listed and I would just summarize this by saying that these are basically all of the various examples, the I codes, (VNM) codes and there are no testing codes so it applies only to examination codes.

On Slide 17 the ICD-9 codes that apply to this measure there are three of them.

They're listed, 362.50 which is unspecified macular degeneration, .51 dry macular degeneration, or .52 wet macular degeneration. So those are the three codes that would trigger this CPT II code to be used.

And I might just say that of these three codes any three of these will trigger this and end up in your denominator.

But of the three codes the more specific codes, .51 and .52, are typically the ones that work better when you're billing insurances as a number of insurances, they look less favorable on the unspecified codes.

So from my standpoint and our practice, I see three main issues as we do this code or any other code.

The first is how do you perform the counseling?

The second is how do you document the counseling in your chart?

And then the third is how do you report the measure?

And of those the first one is one that we've been doing all along. And again I can only say this for our practice or my practice and I suspect this is true for most of you.

And that is that you've been telling the patients about the AREDS vitamins for a long time. It's just now that we have this new program that require to or we have the opportunity to report on it.

And so I will discuss it with the patient and the family primarily in the first visit when the first time we give them a diagnosis of macular degeneration, we'll go over that in some detail.

I will typically give them a handout that has the vitamin information summarized and I use - in our practice we use the Academy's Eye Fact Sheet on macular degeneration.

And if I do a good job on the first visit that'll take a few minutes but on subsequent follow-up visits it's usually very brief. It's usually just are you still taking your vitamins or answering any other question.

So that's something that we have been doing and that won't change. The second thing then is how do we document that we have performed the measure?

And in our practice it's a referral only practice so almost every patient I see, a letter goes out to the referring doctor and there would be a little statement such as, you know, I've suggested the patient take AREDS antioxidant vitamins for their macular degeneration.

We also have to make it easy for patients for if there's a letter that doesn't need to go out for whatever reason we just have a little checkbox on our form that says patient counseled regarding AREDS antioxidant vitamins. And I can just put a checkmark in that box to document that the patient was counseled.

And then finally the third issue is reporting the measure on your super bill.

And the key here I believe is just to make your super bill very easy so that it's easy to remember and easy to document the measure.

And what we do is we group our ICD-9 diagnosis for the three codes that we're using. We group them together so for example for this code we would have our unspecified AMD, dry AMD, wet AMD, they would all be together on the super bill.

And then right above those three measures, those three codes in bold letters would be the F code or the Category II code for counseling for the vitamins and so that just - it's in bold and it's in bigger print and so any time I go in there to mark dry AMD that's staring right at me and all I have to do is circle that.

And so it makes it almost a full proof way to document that code and then as long as your people in your billing office submit it you should basically meet 100% documentation of the code.

And then I will turn - I think (Sue) I think you're going to do the glaucoma one?

(Sue Visherelli): I am. Thank you.

Kirk Winward: All right.

(Sue Visherelli): Very informative. Thank you.

The third test measure which we hope will be a measure is T141 if you're doing the testing. If it actually does become a measure it will be measure 141.

And I'm on Slide 18. This measure is tricky so let's go through it together.

It says primary open angle glaucoma, reduction of intraocular pressure by 15% or documentation of a plan of care.

The description is the percentage of patients age 18 years and older with a diagnosis of POAG whose glaucoma treatment has not failed. That means the most recent intraocular pressure was reduced by at least 15% from the pre-intervention level or if the most recent IOP was not reduced by at least 15% from the previous level and a plan of care was documented within three months.

The instructions read, this measure is to be reported a minimum of once per reporting period for a glaucoma patient seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients for the glaucoma will submit this measure.

Now here's where it gets to the tricky part. There are three Category II codes and two modifiers.

So let's start with the first Category II code.

When reporting you would submit 3284F and this one ends in a 4, intraocular pressure reduced greater than or equal to 15% pre-intervention level. If that doesn't occur then your second option is 3285F.

And that is associated with 0517F. This means the intraocular pressure reduced less than 15% and you have a plan of care.

Now those are the main two that we would be using. It's been reduced or it wasn't reduced and we have a plan of care.

Now comes the modifier, we'll start with the 3P modifier.

In this case and I'm on Slide 23, it is the 0517F that has the 3P modifier. Glaucoma plan of care not documented for a system reason.

And if it is an unspecified reason the 8P modifier again goes on the 0517F 8P not on the 3285F.

So be sure that it is the 84F if you reduce the intraocular pressure equal to or greater than 15%.

And if it is not that, plus you have a plan of care, it's the 3285F plus the 0517F.

Moving on to Slide number 25, there's a 3284F with an 8P indicating the intraocular pressure measurement was not documented, reason not otherwise specified.

On Slide 26 again all of our exam codes whether they be eye codes or E&M codes out of a variety of locations they are all the associated DPT codes.

And on Slide 27 it discusses the ICD-9 codes. You will notice that there are five associated ICD-9 codes listed.

One of the questions that came in prior to our call is can we use this measure for a glaucoma suspect.

Well if you look in the ICD-9 Book for Ophthalmology, 365.01 open angle with border line findings qualifies as a glaucoma suspect.

However 365.02 and 365.03 do not. So it is only those five that are associated with the glaucoma measure.

Okay. Who will be discussing the 2008 measures that are continuing?

Kirk Winward: I can take that. I'd just like to make a comment that just to follow-up on the AREDS situation, the reason why it was dropped for '08, this had nothing to do with the Academy or CMS but these things have to go through final approval through alphabet, one of the many alphabet soup agencies that deal with quality, national quality forum.

At that time the issue was raised of the problems of vitamin E and risk of stroke.

And so it was pulled back so we had to really bring further information to show that doing a subgroup analysis in the ARED study that indeed there was no greater risk.

So that's why it disappeared for a year. It is back now.

I think that the '08 measures, I think we're all pretty familiar with them. The - as a general ophthalmologist it was very easy to participate and the retina people and the glaucoma docs also were able to participate because the glaucoma docs in the practice also see a variety of other patients.

So measure 12, primary open angle glaucoma optic nerve evaluation, 2027F is still (Xed) in.

Again it seems elementary but don't forget in order to get these measures approved tragically we had to document there were gaps and significant gaps in care.

In every one that's really assiduously pursued PQRI has found much to their comfort share that you know what they did overlook looking at the optic nerve or they did overlook explaining about AREDS.

So it becomes like flying a plane. You know if you go through the routine you're less likely to overlook these quality metrics.

And certainly hopefully we'll not see those ten year surprises where all of a sudden when your glaucoma patients so you look and see a big nerve. So that's still going to be around, a very valuable metric.

Measure 14, macular degeneration, dilated macular exam, 2019F, where you document the nature of the macular degeneration, presence or absence of sub-retinal, you know, vascular membrane, the presence of the characteristics of intermediate AMD which would qualify the patient for AREDS.

The measure 18, diabetic retinopathy, diagnosis of the presence of absence of macular edema and level of severity; again we've made tremendous strives in the natural course of diabetic retinopathy over the last 20 years and part of that is the rigid adherence to the recommended intervals for retinal examination. This just continues that initiative started by the Academy in about 1989.

Measure 19, diabetic retinopathy, this is a little confusing. Communication with the managing physician and that would be 5010F plus 37897 or 2021.

Excuse me, I'm sorry.

Again the communication with the primary care physician has been part of our preferred practice pattern for many years.

And it's this reinforcement the role of the ophthalmologist is to reinforce the relationship of the patient to primary care physician the need for good glycemic control.

And basically we've done a pretty good job. We've decreased the need for end stage PRP by 20% in the last ten years. So this is a measure that reminds us to continue that process.

Measure 117 is the dilated exam in a diabetic patient without diabetic retinopathy. It enables us to qualify for this NCQA measure and again this is consistent with long-standing Academy policy emphasizing the need for

periodic retinal examination because most of the early stages of diabetic retinopathy as you know are asymptomatic.

So these measures are - were (Xed) in ’07 and will be around in ’09.

(Sue) why don’t you touch on the HIT, the measures for E-prescribing and medical records?

(Sue Visherelli): Right. On Slide 29 are the two other measures that continue sort of.

Measure 124, health information technology adoption, use of health information technology, electronic health records will continue.

However measure 125, health information technology adoption or use of E-prescribing is now -- and how do I phrase this -- its own reporting mechanism and it’s not part of PQRI.

As I found out yesterday when I listened to the CMS call that this is not one of the three measures that you would report on. It’s a standalone measure.

Kirk Winward: That is correct (Sue). And that was part of the recently passed quote fix that Congress passed quite recently.

And maybe Dr. Green will comment a little bit about the 2% bonus and the phase-in. Actually if that’s going to be part of the rule then we probably can’t discuss it.

But the important thing is to realize that E-prescribing will have a standalone identifier for ’09 and that Congress did mandate a bonus of 2% tapering and then after several years a penalty to come in.

But probably because of rule making we can't get into it any further.

But certainly it's going to be a tremendous stimulus for even ophthalmologists to look at the adoption of E-prescribing. I don't think it's a separate conference call itself to get into the proposed compliance with E-prescribing but probably save that for another day.

Daniel Green: I'm sorry. I was just going to jump in. (Sue) go ahead.

(Sue Visherelli): Oh I was just going to announce that, you know, the Academy is learning as quickly as we can about all of this to share the information with our members.

So certainly updates will be available on the Washington Report, Academy Express, the Coding Bulletin but everything updated links to one source at the Academy and that is www.aao.org/pqri.

And E-prescribing will be a component of that as well.

Also for those on the call who are going to the annual meeting this year in Atlanta we have a pre-course on PQRI and on E-prescribing that we'll be sending November 9th from 12:30 to 1:30.

Daniel Green: I'm going to just jump in here if I may. Just to be clear about the E-prescribing measure. The E-prescribing measure as listed in the 2008 Measure Specification is one of the three measures that can be reported for 2008.

I believe (Sue) said that it will be - its own reporting measure if you will that is a standalone and not one of the three measures for 2009. That is true.

But again that change takes place in 2009. For those of you that may be reporting this measure in 2008 as one of your three measures, please continue to report it. It does count as one of the three measures for 2008.

And for those providers that want to get a jump if you will on 2009 and kind of test to see how you're doing reporting this measure, while it might be difficult to reach the 80% threshold for this measure, if you want to report it as an additional measure for 2008 certainly we would encourage you to do that and that may help to get your office ramped up for 2009.

Just briefly I think Dr. Rich, Dr. Winward and (Sue) are actually quite correct. It would take up quite a bit of time to go into the measure of meeting E-prescribing in great detail.

But just to let folks know there is through the MIPPA legislation which is the Medicare Improvements for Patients and Providers Act of 2008 which was what I was referring to earlier was passed in July of 2008.

William Rich: Better known as the fix.

Daniel Green: The fix. The save our skins.

This allowed for or required us actually for 2009 to allow measure 125 which is the E-prescribing measure to be reported alone.

And under the legislation this measure for 2009 would only need to be reported 50% of the time to qualify for an incentive payment.

However only providers that have ten - if you look at the denominator if those denominator codes make up 10% of the physician's charges or more those physicians are eligible to report this measure.

However if those codes do not make up at least 10% of the charges then the provider would not be able to report this particular measure.

William Rich: Just as a point of information despite the fact that our specialty Dr. Green performs three of the top five surgical procedures by (volume) in Medicare; the typical ophthalmologist generates still 65% of the revenue in the office.

So we would anticipate the vast, vast majority of ophthalmologist and (as well as a) sub-specialist would be able to qualify for the E-prescribing measure.

So I think that we're going to educate our members about the probable applicability of qualifying for that bonus and we're going to get the word out.

Daniel Green: That'd be great because again obviously its one of the Secretary's important initiative in terms of getting folks on board with E-prescribing.

And if you look at the measure it specifies what is considered a qualified E-prescribing system.

So unlike some of the other PQRI measures you actually have to have a qualified E-prescribing system as directed by the manager to be able to report this. You can't say well I didn't have a system and no I didn't write my prescriptions or transmit my prescriptions electronically. You actually have to have the system and be using it.

And again rather than belabor the details for the measure unless there's a lot of questions at the end I'll, you know, suggest folks look at that particular measure on our web site.

But if you think about it it's kind of exciting for 2009 because not only did they "Fix," increase the incentive payment for successful reporters through PQRI from 1.5% to 2%, but it allows for a separate 2% payment incentive for the electronic prescribing measure adoption and reporting.

So conceivably a provider might be able to receive up to 4% of their allowed covered charges under Part B as a payment incentive which if you think about it is pretty much four times, at least four times what they may have received in 2007 because these PQRI they could report for a year and the electronic prescribing of course is for a year. And previously they got 1.5% for six months.

So it's a considerable amount of money that is possibly earned as an incentive payment and we would encourage providers to try to take advantage of that.

Some other things for 2009 as we talked about briefly earlier there - we are in the midst of our rule making so I can't discuss any specifics about the rule.

But the comments are due by August 29th for those folks that do want to write in and tell us their opinions or suggestions.

Talked about how PQRI was made permanent but the incentive is to go forward for 2009 and '10 only and again Congress would have to authorize incentive payments beyond 2010.

The E-prescribing measure does have incentive payments beyond 2010 however although they do go down to 1% in 2011.

The MIPPA legislation also added qualified audiologists to the definition of eligible providers. And also changed a few of the provisions for 2010 and beyond but we haven't begun to consider how we will implement those but that'll be actually outlined in next year's rule making in 2009 for the 2010 program.

So I think I'm going to stop here.

And I'll turn it back to Dr. Rich and (Sue) and if there are any questions as well as Dr. Winward.

William Rich: Kirk do you have any further comments before we open it up to the audience?

(Sue Visherelli): No. We have several people emailed questions in beforehand.

So maybe I believe (Jennifer), would you remind everyone how to queue up for the questions again?

And then let's just go over a couple that were submitted prior to this call.

William Rich: Why don't you read them out and we'll distribute them, okay?

(Sue Visherelli): Okay. We know that when we participate in PQRI we have to report on at least 80% of the measures that we choose for Medicare.

Medicare is a secondary payer and railroad Medicare.

However will this participating extend to Medicare HMOs, PFFS or Advantage Plans?

William Rich: The answer simply is no. It hasn't in the past and I don't - there's nothing in MIPPA that's going to change that. Is that correct Dr. Green?

Daniel Green: Yes. That is correct. Medicare Advantage folks - it's only Medicare Part B fee-for-service patients that you can report on and be subject to our - I'm sorry, be allowed to get a payment benefit (on this group).

William Rich: Another great advantage to physicians to participate in Medicare Advantage, you make less money and then you don't get a bonus for PQRI so that's an editorial comment that did not come from CMS.

Daniel Green: Thank you for pointing that point out. I may have a job for another day.

(Sue Visherelli): Let me ask another question and then we'll open it up for our callers.

May we attach more than one diagnosis as long as the first diagnosis is the one that is linked to the Category II code?

For example if measure 18, the Category II code 2021F, and the attached diagnosis code relate to other things going on with the patient the first diagnosis is linked. Would it hurt us to have additional diagnoses that are not linked?

William Rich: My understanding is no. How about you (Sue)?

(Sue Visherelli): My understanding is as long as they - the PQRI diagnosis is listed first for the exam and then these ancillary diagnosis codes that don't pertain to PQRI are

not attached to the PQRI code, they can be for the exam but not for the PQRI code.

William Rich: Let me just and Kirk you might want to chip - just a practical matter in a busy office, we may have listed seven or eight different problems.

But in my group on our - in our 1,500 forum we actually just put down the major diagnosis that drove the exam that qualifies for PQRI.

And we may add a secondary diagnosis if it's related to a diagnostic test for instance if you did a tachometry for intraocular hypertensive.

But so we've really cut down on the number of diagnoses we submit to help with the clarity.

And what's been your approach Kirk?

Kirk Winward: That's what we do as well. We, in our chart we'll list all the various diagnoses but what we send in to the CMS is basically just what justifies the various things we've done, a diagnosis for the exam, a diagnosis for any testing. And we limit it to that.

(Sue Visherelli): Thanks. Let's take questions from our participants.

Natalie Highsmith: Okay (Jennifer) we're ready to move into our open Q&A, if you can just remind everyone on how to enter into the queue to ask their question.

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

Operator: At this time I would like to remind everyone if you would like to ask a question press star then the number 1 on your telephone keypad.

Your first question comes from (Sandra Ranik).

(Sandra Ranik): Hello. This is (Sandra Ranik) from Horizon Eye Care.

And my question is related to the T139 code measure going forward. I don't quite understand how that is different from what it was in 2007.

Daniel Green: I'm sorry. You said T139?

(Sandra Ranik): Yes. The cataract...

((Crosstalk))

(Sue Visherelli): Right, the cataract comprehensive preoperative assessment.

(Sandra Ranik): Right.

Daniel Green: How that's different from the measure that was - I'm sorry can you ask that again.

(Sandra Ranik): Sure. How does the one proposed for 2009 differ from the 2007 measure.

William Rich: I think the, this is Bill Rich, the most important difference is the functional - the statement on functionality, how it affects the function of the patient.

And actually that's been a requirement for documentation of surgery...

(Sandra Ranik): Right.

William Rich: ...for a long time. But this time it's really spelled out in the measure itself. It's something that we've typically done.

But unfortunately it - some surgeons, you know, have not documented how a 20/50 vision affected the patient and what their complaints were.

So this just codifies that.

(Sandra Ranik): Okay, I just wanted to make sure that I'm not missing something here because...

William Rich: No, it's...

(Sandra Ranik): ...that's the way that we do it.

William Rich: Yeah, that's the way. That's standard of care but the measure itself is a little different from the previous cataract measure...

(Sandra Ranik): Okay.

William Rich: ...from '07.

(Sandra Ranik): Okay.

(Sue Visherelli): As I recall there was the assessment. And that was billed with your exam. The dilator component was billed with your surgery.

Now they've gone with the assessments and the dilator, the exam, only with the surgical code not with the exam code.

William Rich: And I think this really represents a long term trend about component measures bundling different things together.

And I think we're going to see that in the future. The agencies that develop measures, they're asking specialties to try to think of composite measures is the applicable term, to really look at diabetes or macular degeneration and come up with a measure that instead of having three or four measures to think of a way to integrate them into one composite measure.

So I think this represents a long term trend.

(Sandra Ranik): Okay. I also have a second question and this may not be the right forum.

But with our 2007 and our incentives, when we went through the report we were informed that we did 81 more surgeries than we actually did and we can't find the additional 81 surgeries.

William Rich: I guess the problem would be whether you guys paid for them or not.

(Sandra Ranik): Yeah, oh good point, very good point. Oh well no. Actually I went based on whether we did them or not.

William Rich: Yeah.

(Sandra Ranik): Not whether we even submitted them. I don't know. I am not sure the 81 that they're talking about.

William Rich: Yeah, right no idea.

(Sandra Ranik): Okay. All right, thank you very much.

Operator: Your next question comes from (Sharon Deconio).

(Sharon Deconio): Good afternoon. We have been utilizing the PQRI since 2007 with our family consultants on Long Island.

And we're currently doing them for 2008.

I have a question in regards to the glaucoma measure which is pretty confusing to say the least.

((Crosstalk))

(Sue Visherelli): You're talking about the new measure...

(Sharon Deconio): Yes.

(Sue Visherelli): The new proposed measure (right).

(Sharon Deconio): For 2009.

(Sue Visherelli): Yes.

(Sharon Deconio): Those two codes, the 0517F and the 3285F, those have to be put on the claim form together.

(Sue Visherelli): They do.

(Sharon Deconio): Okay. And the modifier only goes on the first, the 05 code not on the 32. You never put a modifier on the 32 code.

(Sue Visherelli): You do on the last one. It was Slide 25...

((Crosstalk))

(Sharon Deconio): That was on the 84 one, right?

(Sue Visherelli): That's on the 3284F. So the 85F never gets a modifier.

(Sharon Deconio): Okay, great. And the other question I have has there been any mention, I was on the call yesterday also and I hadn't seen any mention of, well they actually didn't even touch base on this, about measures qualifying for the incentive going up from three or is it - or you only have been hearing that it's only three measures are the ones that are going to qualify you for the incentive program?

William Rich: So I think...

((Crosstalk))

William Rich: ...why don't you handle that. I think a couple of us will have comments.

Dr. Green.

Daniel Green: I'm sorry. Thank you. No. For 2009 we anticipate that there will be three measures that will - if you successfully report on 80% of eligible patients for three measures, you will qualify for an incentive payment.

There are, as you know, even for 2008 several different options most of which probably would not apply to ophthalmologists in that we have the measures group but there is not an ophthalmology measures group in 2008.

So the standard way for an ophthalmologist to earn an incentive payment would again be the 80% of three or more measures going forward.

So it's not really going to change from the three measures. Where you may have heard that again, some of the measure groups require folks not to report on absolutely every single patient but may require 30 consecutive patients with a particular condition and in the instances of measures groups its more than three measures.

So like for diabetes there are five measures that a provider must report on for each 30 consecutive patients to qualify for the incentive payment.

But for ophthalmologists since there is no measures group you would require three more measures on 80% of the eligible patients.

William Rich: So I think some of the confusion is between the mandate to - if you're eligible, if you can report on three measures which ophthalmologists can, and the number of measures that are going to be available to be reported on so even if the measures doubled you still - you don't have to double the - you still have to report on 80% of just three measures.

(Sharon Deconio): Okay.

William Rich: I think there was some confusion that because there were going to be more measures the number of measures you had to reach that 80% threshold was going to increase and that's not true.

(Sharon Deconio): Great. That's wonderful.

Also the - I had heard on the call earlier that (Sue) had mentioned about on your exams when you're reporting currently that the primary diagnosis should be the PQRI diagnosis and then other subsequent diagnoses in the second, third and fourth area and so on.

When I was on calls with CMS previously they had stated and I had asked this specifically if the PQRI code for the exam needed to be the primary diagnosis and they said it did not and for my local carrier.

Now I don't know if that has changed but I'm not seeing any reflection on that on my EOB.

On the PQRI code I am definitely only reporting the PQRI corresponding diagnosis.

But on the exam codes if the code corresponds to a PQRI measure I was told it didn't - it could have been in any one of the four spots or so on because electronically now they can receive more than four diagnoses.

William Rich: Well I think that's why we put only submit two.

Kirk what has been your group's approach to simplifying this to help not overburden the clerical people in the front office?

Kirk Winward: Yeah. It's like I said earlier we try to make it simple, the least amount that gets our claims to go through cleanly.

William Rich: That's what we do too. We never submit more than two diagnoses.

(Sharon Deconio): I think I would like to come work with your physicians.

William Rich: You need less compulsive ophthalmologists in your group (basically).

((Crosstalk))

(Sharon Deconio): That was the hardest part and the challenge - most challenging part for us here. We have 20 doctors and getting them all, you know, on the same page with PQRI was a little challenging.

And I was appreciating the fact in the beginning that you were so positive about saying that it was kind of easy for you to implement it into your practices.

We - it wasn't as easy in ours but we have done it and it's been successful so I'm happy to say that.

(Sue Visherelli): Right. And it's nice to know that you've been successful with reporting the diagnosis as not the primary diagnosis but it certainly doesn't help to get it in there first.

(Sharon Deconio): Right.

(Sue Visherelli): Doesn't hurt to get it in there first.

(Sharon Deconio): Right.

William Rich: I agree.

(Sharon Deconio): I don't disagree. Thank you very much for your time.

William Rich: You're welcome. Having grown up in New Jersey, your voice - your accent is just wonderful sound to my ears.

(Sharon Deconio): That's great. I'm glad to hear it.

Operator: The next question comes from (Marybeth Hall).

(Marybeth Hall): Hi. Good afternoon. I have a question on the cataract one.

And it says that you need to have a fundus examination and then the measurements of the eye, the axial length. Those are normally done on different days.

Now do - am I eligible to still report that PQRI code on that fundus exam...?

William Rich: Absolutely.

(Marybeth Hall): ...without the axial length being done because that's normally done...?

William Rich: Absolutely.

(Marybeth Hall): ...at a later time?

William Rich: None of these things are all done on the same day, the cataract extraction with the IOL, the examination of the fundus and the biometry.

Basically this is a form of composite measure. You're looking at three things and evaluation of the functional needs of the patient.

They can be - they're not going to be done on the same day. They're done on different days and there's no requirement that the measure would be billed when the surgery is billed.

Is that correct (Sue)?

(Sue Visherelli): That's right.

William Rich: Yeah.

(Sue Visherelli): Remember that you would just submit your claim for your exam. You submit your claim for your A-scan. The PQRI Category II code goes with your surgical code.

William Rich: Exactly...

((Crosstalk))

(Marybeth Hall): Oh it goes on the surgery code.

((Crosstalk))

William Rich: So it's very, very simple.

(Sue Visherelli): Surgical code not the exam code, not the A-scan code; surgical code.

(Marybeth Hall): Okay.

William Rich: So again you see this concept of a composite really making things a little easier.

(Marybeth Hall): Okay. So this goes on the surgical code.

William Rich: Correct.

(Sue Visherelli): Right. Slide number 10.

(Marybeth Hall): Thank you.

(Sue Visherelli): (6698283 and 84).

William Rich: Right.

(Marybeth Hall): Oh.

Kirk Winward: Let me interject just for a second. You know we work with this stuff all the time and those folks that have already adopted whichever measures they're going to report its second nature to them.

But something I might suggest is when you're considering a particular measure to report obviously you'll look at the title to see what it's about.

But the other thing, the next step I would suggest is looking at the denominator to see which patients would be included and which patients - so which patients are candidates for the measure.

And looking at the measure that was just, you know, in question, you can see that the denominator it actually has the surgery procedure code that you all were just describing.

And I think sometimes that makes it a little bit easier for folks when they're just starting to work with PQRI.

William Rich: I think that's a great point. And that's one of the things we did when we had the different sub-specialists in our group, Kirk, sit down and select measures. I think that's a great point.

(Marybeth Hall): Thank you.

Operator: The next question comes from (Colleen Michaels).

(Colleen Michaels-Walsh): I always forget about the mute button, sorry folks. This is (Colleen Michaels-Walsh). I'm calling from Tufts Health Plan in Watertown, Massachusetts.

And I hope you like my accent as well as you liked the person from New Jersey.

William Rich: I do. It's a wonderful German name you have too.

(Colleen Michaels-Walsh): Oh exactly. And a Boston accent at that.

But the reason why I'm calling in the call I heard that this PQI doesn't pertain to Medicare Advantage Plans.

William Rich: Correct.

(Colleen Michaels-Walsh): It does. And there was guidance on HPMF released on June 27th and it was a memo and regarding PQI.

And in it what it says is this payment information for MA Plan, it will pertain to MA private fee-for-service or (PFFS) and non-contracting providers in MA Plans so will affect MA Plans in 2008 and into 2009.

So I just wanted to put that information out there if folks didn't know that.

Daniel Green: Did you get that from your carrier?

(Colleen Michaels-Walsh): No. This came directly from CMS. It was posted on the CMS HPMF which is the web site where they post information or changes that relate to - I don't think it's explicit to MA Plans. I think any provider can get - can obtain those.

And the date of the memo is June 27, 2008 and it's directed to all plans and it's from Tom Hutchinson, Director of Medicare Plan Payment Groups and the subject is PQI Initiative 2007 Data File is the subject of the notice.

Daniel Green: Do you mind giving me your phone number so I can get that link...?

(Colleen Michaels-Walsh): Sure.

Daniel Green: ...after the call?

(Colleen Michaels-Walsh): I'd be glad to. We're - again I'm in Boston so it's area code 617-972...

Daniel Green: Okay.

(Colleen Michaels-Walsh): 9400.

Daniel Green: Okay.

(Colleen Michaels-Walsh): Extension 8556.

Daniel Green: 8556.

(Colleen Michaels-Walsh): And I keep listening in all the calls I can hoping someone will tell me that it doesn't tell - it gives you some information but doesn't give you all of how to report so I keep hoping one of these calls I'll get all the details I need.

But I figured I would share that since I was listening in the call and I wanted to share that information with everyone.

Daniel Green: Yeah. We'll research it and clarify it but that's not my understanding.

(Colleen Michaels-Walsh): Okay, well if you find different information please share, because I would really...

Daniel Green: We will.

(Colleen Michaels-Walsh): ...appreciate that.

William Rich: By the way we knew you were from Boston when you said PQI because you left your R out.

(Colleen Michaels-Walsh): Oh.

William Rich: I wondered why you did that.

((Crosstalk))

(Colleen Michaels-Walsh): (Unintelligible) us in Boston. We don't even park our cars.

William Rich: Park your car you mean.

(Colleen Michaels-Walsh): Exactly. They say park the car in the Boston garage and there we go.

William Rich: Thank you.

(Colleen Michaels-Walsh): Thank you. Have a nice day everyone.

Daniel Green: We'll research it.

(Colleen Michaels-Walsh): Thank you.

Operator: The next question comes from (Ann Holitz).

(Ann Holitz): Yes, I'm calling from Pueblo, Colorado.

And I have a question regarding the ERX requirements. You commented a moment ago about it will require a qualified system. I was wondering if that equates to a certified system.

Kirk Winward: Would you be more specific please about what you mean as a certified system?

(Ann Holitz): Well one of the vendors, SureScripts which is one that many people will be associating with is listing certified systems that they're communicating with as opposed to a longer list of IT vendors that are not certified.

Kirk Winward: Right.

(Ann Holitz): And I was curious whether or not the qualified system equated to a certified system.

Kirk Winward: That's a great question. Not necessarily is the short answer.

SureScripts is the network through which SureScripts RxHub is the network that most of the electronic prescriptions if you will travel over to get to the pharmacy from your office or through to the payer, etcetera.

So not every single certified - I'm sorry. Vendors that want to be able to work over this network have to go through SureScripts RxHub's certification process.

So there are certain requirements and standards that they have to certify a program but not all of the programs will necessarily meet the requirements that are outlined in our measure.

So I would encourage you. It's a great starting point however to learn about the different vendors if you are considering purchasing a system. But you would want to make sure when you - to interview the potential vendor to

make sure that they can meet all the qualifications we've outlined in the measure 125.

William Rich: It should - and this is again why I didn't want to get - this is Bill Rich - too much into this.

But the Academy is looking into a collaborative effort with the American Academy of Family Practice and SureScripts to educate the members on, you know, the difference between certification and qualification.

And you'll be receiving some input from the Academy in the near future. We're finalizing a relationship now and we hope to get that out to all interested parties.

(Ann Holitz): Okay. Thanks guys. I also wanted to say thanks for your efforts on this. I also think that the addition of the three new factors for 2009 is a plus for all of us. Because regardless of whether - how complex they are or they aren't they give us three more choices to choose from. And I would think would increase the simplicity and odds of our success in taking part in the PQRI.

So I think the more factors we have the better off we are. So I appreciate your efforts.

William Rich: And again any final determination of what they will be in the final rule.

(Ann Holitz): Right.

William Rich: And once - usually comes out in the beginning of November, God willing, and once we've digested it we'll get out the information to all the membership.

Kirk Windward: And I appreciate the last comment. If you are so inclined please do send that to us in the form of a written comment responding to the rule so we can formally consider that.

Thank you.

(Ann Holitz): Okay, thanks.

William Rich: It's our incumbents.

Operator: The next question comes from (Kay Solvino).

(Kay Solvino): Hi. This is (Kay Solvino). I'm calling from State College, Pennsylvania, Heimer Eye Care Associates.

I have a question regarding the feedback reports. I've heard a couple people mention that they listened into the CMS call yesterday as I did.

And they seem to say that the feedback report would describe for you why you got your incentive.

I'm looking for information why I did not get my incentive because in 2007 we thought we did a pretty good job. I have had trouble accessing the feedback report through the online method and I wonder if anybody could give me some help on that.

Latasha Leslie: Hi. This is Latasha Leslie. Have you been able to access your report at all to see what's on it?

(Kay Solvino): I have not.

Latasha Leslie: Have not.

(Kay Solvino): And I got a thing that said that, you know, I even printed it out that the organization search didn't work and I did it a couple different ways.

So I have not seen it but I don't know how much to pursue it unless it's going to give me information about why I didn't get my incentive.

Latasha Leslie: Do you have an IX account? That's key to accessing the report.

(Kay Solvino): But that's what I'm saying. I couldn't get in - I couldn't complete the IX registration.

Latasha Leslie: Okay.

William Rich: Actually you may or may not have gotten a bonus because several people and not all the checks have gone out to the best of my knowledge so.

(Kay Solvino): Oh I thought they had.

Latasha Leslie: The checks were - have been mailed during the period of July 15th through July 31st of this month or last month, 2008, the carriers who you normally submit your Medicare billings to who are responsible for mailing out the checks.

So the first thing I would advise you to do is contact your Medicare Part B carrier to ask if you have an incentive payment and was your incentive payment mailed out. That would be the first step in determining whether you received instant payment.

If you have multiple carriers that you bill your services to then you need to call the multiple carriers.

(Kay Solvino): Okay.

Kirk Winward: There are also, you know, some of us in the middle Atlantic states have a new carrier that changed over July 11th.

So I think that there have been some regional variations on receiving the checks and that may have something to do with it.

(Kay Solvino): Okay. Would that have anything to do with not being able to get the IX?

Latasha Leslie: No. Not being able to get to IX is out of the control of the carriers. They can only tell you if they've sent you an incentive payment under a Tax ID or MPI number that you're billing under.

Getting into IX is handled by the User Help Desk, the EUS User Help Desk, External User Support and they can help you with getting new IX login or troubleshooting that.

I can give you that Help Desk telephone number.

(Kay Solvino): Okay.

Latasha Leslie: Hold a minute. That number is 1-866-484-8049.

(Kay Solvino): And is it will it be a toll for me even if I have not gotten an incentive or is it only for people who do get incentives?

Latasha Leslie: The feedback report is intended for folks who did and did not receive an incentive.

(Kay Solvino): Okay.

Latasha Leslie: But you would have had to submit a valid code, meaning your denominator code and then the CPT 2 code from the measures that you submitted had to match what's in the measure specification so you had to have submitted 80% on your eligible patients for those measures that you selected.

(Kay Solvino): Okay, so there wouldn't be a feedback if I didn't do all that?

Latasha Leslie: Right.

(Kay Solvino): Okay. So if the problem is the 80% then I won't even have a report?

Latasha Leslie: What's that question again?

(Kay Solvino): If I didn't meet 80% then I will not have a feedback report?

(William Rich): If you submitted a qualified code in other words a CPT 2 that was appropriate for one of the CPT 1 denominator codes, you should have a feedback report.

So even if you, pardon the expression, failed, you know, reaching 80% you should still have a feedback report.

(Kay Solvino): Okay, great.

Kirk Winward: Maybe we can help anticipate some further questions because there have been as you know new contractors who are assigned and some of them just changed in July.

Can we answer members' questions who they should make the inquiry of for the carrier, the one prior to the switch over July 11th or the current carrier?

Daniel Green: Give us one second here if you may please.

Kirk Winward: Sure, while we're researching that maybe we should go ahead with the next question.

(Kay Solvino): Thank you very much.

Kirk Winward: You're welcome.

Operator: The next question comes from Sandra Hartigan again.

(James Warren): Hello. This is Dr. (James Warren). I'm working with Sandra Hartigan from Metropolitan Eye Center in St. Clair Shores, Michigan.

We are novices with regards to PQRI and are going to start implementing PQRI services next month.

And my question is whether the measures with regards to glaucoma and diabetic retinopathy apply for each visit or are they annual requirements. Say the optic nerve examination.

Kirk Winward: That's one year. That's 12 months.

((Crosstalk))

(James Warren): So if I see a patient three times for glaucoma care, I basically should report the PQRI each time but the eligible visit is only once per year then?

Kirk Winward: That is correct.

(James Warren): And the eligible charge is what I'm (paying).

Kirk Winward: Yeah. The practical way of implementing this in your office, I'm a general ophthalmologist.

(James Warren): Yes.

Kirk Winward: And so we have a little code between the technician and the physician.

And if the technician, you know, goes in to see the patient, they see they were not dilated the last visit, they make a notation to the physician coming into the room that indeed at the last six months visit there was no dilated exam of the optic nerve.

And it's a little tickler to us that indeed it's time to look at the optic nerve. We then dilate them, look at them with a (Volk) lens describe the nerve and any change.

But that's a 12 month code.

(Sue Visherelli): Let me read the actual measure. It says percentage of patients age 18 and older with a diagnosis of primary open angle glaucoma who have an optic nerve head evaluation during one or more visits within 12 months.

So the one visit within the 12 months should work.

Kirk Winward: That's correct.

(Sue Visherelli): However if you're a little bit leery about that and I don't know why you would be.

But if you are you could document it with the Category II code, 2027F and the 1P modifier; 1P modifier says there's a medical reason for not performing the optic nerve head evaluation. That medical reason would be you've already done it.

(James Warren): Yeah, actually the root of my question boils down to what are the eligible visit codes that apply toward the incentive, say for instance I mean, you know, you have three visits and so you have three different codes and three different reimbursements and X number of dollars.

Does the incentive apply just to the one yearly exam from a financial point of view or does it apply to that patient and his billings throughout the year?

Kirk Winward: I think (Sue) and I will both attack that and it's any of the eye or EM codes during a 12 month period where you - where during that exam you've dilated and documented the status of the optic nerve.

Does that make sense?

(James Warren): Well that might happen two or three times a year then.

Kirk Winward: But if I'm understanding your question correctly actually the incentive payment is calculated based on your total covered Medicare fee-for-service dollar so.

(James Warren): Oh not just the glaucoma dollars but the total dollars.

((Crosstalk))

Kirk Winward: Oh, I'm very sorry. Oh for every patient you saw if you did cataract surgery on somebody but you aren't even reporting the cataract measures, those charges if they're covered under Medicare Part B would be included in the total that we figure your bonus.

So it wouldn't just be on the patients that you report.

(James Warren): It's just on the total - it's on the total...

((Crosstalk))

Kirk Winward: Whatever (unintelligible) in total if it's under the - if it's through the covered Medicare Part B fee-for-service patient...

(James Warren): Yes.

Kirk Winward: ...whatever that is at the end of the year be it 100,000, be it 200,000 or more...

(James Warren): Yes.

Kirk Winward: ...that's where that 1.5% for '08 and then 2% for '09 would be calculated. Not...

(James Warren): So essentially it's on all of our Medicare billings.

Kirk Winward: That is correct. I'm sorry, I misunderstood your question.

(James Warren): Yeah, well thank you. I mean as I said I'm a novice so I'm trying to put this together and that certainly increases the incentive doesn't it.

Kirk Winward: That sure does.

(Sue Visherelli): Kirk let me add that it does not count toward any injections, any J codes that you may inject in the office or your durable medical equipment, any optical.

(James Warren): Right, thank you very much.

(Sue Visherelli): That's excluded.

((Crosstalk))

Daniel Green: Under consultation I and EM codes.

(James Warren): Yes, thank you.

Daniel Green: Please be reminded though when you are submitting quality data codes to submit it using your MPI and Tax ID number and also when you're submitting claims that do not have quality data codes attached to them, please bill those under your MPI because that's how the number is obtained in calculating the payment incentive.

(James Warren): Thank you.

Kirk Winward: Our initial analysis, that's a great point, Dr. Green, our initial analysis with people that where the docs and the technicians assiduously adhere to a group plan to participate in PQRI and they didn't qualify it. It happened at the other end of the office on the billing side where the MPI was not part of the submission.

So (Sue) has that been your experience too?

(Sue Visherelli): Unfortunately yes.

Kirk Winward: Yes.

(Sue Visherelli): And it's a bad scenario.

Kirk Winward: Yeah.

(Sue Visherelli): Can I ask one question before we move onto additional callers. One person asked and I think this is the representation of both. They are in a group practice where not everybody in the group wants to participate.

Will those who do participate say its one doctor out of five, will they be rejected because not everybody in the group participates?

Kirk Winward: Absolutely not. The - and Dr. Green and your colleagues from CMS want to follow-up on that.

But basically the individual physician participates and qualifies for the bonus. The check is mailed to the group entity.

So in my group of ten if two opted out or only two - it doesn't make any difference; the bonus will go to the two, anyone that qualified for it but the check is mailed to the group.

Daniel Green: That's a great point. And then just to follow-up and add to that, the same patient can be counted for different practitioners within a group.

Let's say Dr. Rich and Dr. Winward are partners and so Dr. Rich sees Mrs. (Jones) today for her glaucoma evaluation but six months from now Dr. Winward sees her because Dr. Rich is on vacation or what have you.

Well if Dr. Rich is - I'm sorry. If Dr. Winward is reporting the same measure as Dr. Rich, he can report that on that same patient the same measures.

So it does require a separate visit. In other words they both couldn't report that patient off of the first visit because obviously only one of them is going to bill for that first visit.

But if the patient is seen by a partner or colleague at a subsequent visit and that visit is in a denominator then they can bill - they can submit that quality data code and would be expected to if they're reporting on the same measure.

(James Warren): And Dr. Green then if I understood that correctly if my partner sees a patient with macular degeneration and counsels on vitamins and then I see him later and say well that's been done in our practice and I don't submit the code, that's tracked by physician and not my practice.

And so that would be in my denominator and would reduce my percentage even though in our practice that patient had been counseled.

Daniel Green: And for 2008 and 2009 that is exactly correct.

(James Warren): Okay.

Kirk Winward: Great question.

Daniel Green: But you can still report it. You could report it with an exclusion modifier as to why you didn't do it.

But and so you still get credit for reporting which is how we're paying PQRI currently.

So it may affect your performance numbers but it shouldn't affect your performance numbers, I'm sorry, your reporting numbers.

Kirk Winward: And one question that I get a lot and (Sue) may get this too Dr. Green, is there any penalties?

Suppose let's go back to a glaucoma patient. You saw them six months before and you've dilated them and you billed the appropriate Category II code.

You see them again six months later and even though it's within 12 months and you bill it again you're not penalized for - the question is are you penalized for billing the Category II code a second time within the year's period of time?

Daniel Green: Now there is no penalty for over reporting. It's only for under reporting.

Kirk Winward: Correct. And I think some physicians were concerned about is there - you know if they do do it and the answer is no, that the - you're only going to get credit for meeting the measure within that 12 month period one time.

Hello?

Daniel Green: Yeah, I'm sorry. There was another question that came up in the room.

Could you - I'm sorry. Can you repeat your question please?

Kirk Winward: My question was that a lot of docs, they said, you know, is there anything wrong if the measure - there's a 12 month period for the measure. Patient comes in and you report it twice.

Is there any penalty for it? And our response has been no.

But you're only going to get paid one time for meeting, you know, that one patient during that 12 month period.

Daniel Green: That's absolutely correct. So it would count once in the denominator and if you reported that you did the quality action it would count once for your performance.

So you won't get, you know, if you report on the same patient let's say four times you're not going to get oh well that's four out of four for reporting. You're going to get one out of one.

Kirk Winward: That's correct.

Daniel Green: And if you don't report it the second time there's no penalty for that.

But we do encourage folks to - I mean I know personally I would rather report it on every patient because I'd be well I don't remember if I reported this last time. Just to be on the safe side.

But and there is no penalty for that whatsoever but you don't get extra credit on (it).

Kirk Winward: And that's the point to be made. I just didn't phrase the question appropriately because some of my partners do report it every time.

And they were wondering gees, is that wrong. And I said no, the computer is going to keep track of it.

Daniel Green: Thank you.

(Sue Visherelli): I think we're ready for another question.

Operator: The next question comes from (Bernie Ann Lewis).

(Bernie Ann Lewis): Thank you. Our question has actually been answered.

Operator: The next question comes from (Fran Hyatt).

(Fran Hyatt): Hi this is (Fran). I'm in Alabama with Eastern Medical Eye Center.

And I had a question similar to the lady in New Jersey but an opposite accent regarding not reporting the PQRI diagnosis as the primary diagnosis on the exam code.

I always thought that the primary diagnosis on the exam code was always the chief complaint.

But if one of the other services are performed during that visit that's how we've been reporting it at the second or the third diagnosis on the exam but the primary and only diagnosis on the (PQRI).

(Sue Visherelli): And have you previously successfully report? Did you get a check?

(Fran Hyatt): Yes.

(Sue Visherelli): And you successfully reported?

(Fran Hyatt): As far as I know. I'm still in the application process for the IX.

(Sue Visherelli): Okay. But did you get a check?

(Fran Hyatt): Yes.

(Sue Visherelli): Okay. Then it looks like you successfully reported.

(Fran Hyatt): Okay but so is that not true anymore that the chief complaint...?

(Sue Visherelli): No. It is still true. Remember there are the standard rules for coding.

(Fran Hyatt): Right.

(Sue Visherelli): And then there are the PQRI implementation.

(Fran Hyatt): Okay.

(Sue Visherelli): So whichever. Both are appropriate to be paid. So whichever one guarantees payment that's the way you follow.

(Fran Hyatt): Okay. Well I just got confused...

((Crosstalk))

(Sue Visherelli): So if it's not a patient...

((Crosstalk))

(Fran Hyatt): ...when the guy said that he just reported the PQRI diagnosis for the visit.

(Sue Visherelli): But that could be the chief complaint as well.

(Fran Hyatt): Yeah. I mean if it is obviously.

(Sue Visherelli): Right.

(Fran Hyatt): But if it isn't...

((Crosstalk))

(Sue Visherelli): I would want...

((Crosstalk))

(Fran Hyatt): ...it has been working for us as well.

(Sue Visherelli): I would want it first or second.

(Fran Hyatt): Right.

Kirk Winward: I'm not an expert on this. And unfortunate...

(Fran Hyatt): Me either.

Kirk Winward: ...unfortunately we don't have somebody from CMM which would be able to - who would be able to give you a definitive answer.

But my understanding is as long as the diagnosis code as well as the CPT code so the service code, along as they appear there and so in other words all the components of the denominator are on the claim, you should be able to submit the CPT 2 code with that.

(Fran Hyatt): That's how we've been operating.

Kirk Winward: Right. And it should qualify. That's my understanding of it.

But...

(Fran Hyatt): Okay, and that's how I interpreted it as well so I just...

((Crosstalk))

Kirk Winward: We can try to get confirmation of that from our folks in CMM.

(Fran Hyatt): Okay, thank you.

Daniel Green: Welcome.

Operator: The next question comes from David Sobczak.

David Sobczak: Good afternoon. It's David Sobczak from Toledo, Ohio, Vision Associates.

And we don't have any accents here either.

Just one comment and a question; we found that getting the IX permission to see the results was a lot more difficult than producing the results over the six month timeframe actually. It was very involved. A lot of support calls were required.

And didn't know that we set ourselves up as security officer and that doesn't give you authorization to see any of the information. You have to be a Group Account Manager.

So there was a lot of confusion in our group as to how to get the result. We finally did. So that's taken care of.

But the other question. I heard a reference earlier about public disclosure of the results.

Will that ever be made of 2007 results or are they talking more like 2008 and '09?

Latasha Leslie: Hi. Performance results for PQRI are not intended to be disclosed for the public.

Kirk Winward: Didn't know that. The long term public policy initiative however is to enable patients to better - to make a more "Informed patient" to help them in their decision making and I think I didn't mean to mislead you to suggest that the current data was going to be public and reported.

But certainly in the commercial sector it is. And long term I think it will be.

But it's not at this time.

David Sobczak: Okay.

Kirk Winward: But its very clear that that's part of the entire quality initiative that's being driven by patients.

David Sobczak: Yeah, it's definitely the message that we're seeing. We just weren't sure if that was going to be implemented now or that was the plan eventually.

But it sounds like it's not initially at least so that is...

((Crosstalk))

Kirk Winward: And I'm sorry if I misled you in my comments before.

David Sobczak: Okay. That answers my question.

Kirk Winward: Thank you.

David Sobczak: Thank you very much.

Kirk Winward: You're welcome.

Operator: The next question comes from (Tracy Cummins).

(Tracy Cummins): Yes, thank you. I'd like to jump back to E-prescribe if possible.

When you mentioned that the Academy is going to be coming out with some information, will your information include the - maybe many systems that are available to look at?

We have not looked at this at all so I'm starting from scratch and my...

((Crosstalk))

William Rich: I think we all are.

(Tracy Cummins): Okay.

William Rich: And we've had some exploratory calls again with the American Academy of Family Practice and others. There's a nonprofit group that kind of acts as a data center to collate and collect the different vendors and we plan on exploring a working relationship with them.

The American Academy of Family Practice has been very pleased with the service their members have gotten.

But when this will be implemented I don't know. I think we just had our first call with them last week.

(Sue) anyone else want to comment?

(Sue Visherelli): You've said it beautifully. That's as much as we know.

William Rich: Okay.

Cherie McNett: This is Cherie McNett in the Washington, D.C. office. I do believe that the web site has gone live for that now.

William Rich: It has, great.

Cherie McNett: And it's www.aao.org/e-rx.

(Tracy Cummins): I appreciate that. Thanks. Thank you very much.

William Rich: Shows you your staff knows ten times more than the docs, right?

(Tracy Cummins): Thank you very much.

William Rich: Thanks Cherie.

Daniel Green: Just to add to that, folks that if they want to get a jumpstart on that or it's maybe useful to go to the RxHub web site. RxHub deals a little bit more with the formulary type stuff where SureScripts deals more with the or dealt with more with the transmission of the prescription.

Anyway those two companies as you probably know have merged and become one company...

((Crosstalk))

William Rich: Correct.

Daniel Green: ...so we've (got) the best of both.

William Rich: Just so this summer, yeah.

Daniel Green: Exactly. So I found it helpful actually just to go on the RX web site and start looking at some of the different vendors there and then they actually even have tables there that talk about some of the functionality. That may be a good starting point for folks that are, you know, want to do their early research, you know, before the final recommendations from the Academy are released.

William Rich: Thanks a lot (Tracy).

Natalie Highsmith: Okay (Jennifer) we are getting closer to our 3:30 hour here on the East Coast and I'd like to turn the call over to Dr. Green and the staff on the line from AAO for any closing remarks. Dr. Green.

Daniel Green: No. I just would like to thank everyone for their time and participation today. We had some great questions that came up on the call.

And I think Dr. Rich, Dr. (Woodward), I'm sorry, Winward and (Sue) I think all three of you did a wonderful job presenting the new test measures and explaining how you've implemented PQRI in your practice.

I think that as you all pointed out initially, you know, it seems a little bit like a burden but once you get used to it it's really only a few extra minutes and it does help to ensure we are providing the highest quality of care that we can to our patients.

So I want to thank our panelists today for presenting these and for helping to arrange this call and the slides and for everyone else for their attendance and interest in PQRI.

And Dr. Rich and Dr. Winward, (Sue) I'll turn it back to you three for the final closing remarks.

William Rich: Again I'd just like to thank our colleagues at CMS for hosting the call and allowing us to participate.

And again this has been part of our culture for over 20 years and this is one way of implementing it and helping us to adhere to our own adopted measures that we agree on but sometimes get overlooked in the busy pressures of practice.

So this is just a start of a long term process. Again thanks a lot Dr. Green.

Kirk Winward: And I would just second that. Thanks Dr. Green. It's very helpful when we get the folks from CMS who can answer our questions definitively. There's often a lot of little questions that we try to answer on our own but it's always best when we can hear it from the horse's mouth so thank you very much.

Daniel Green: Thank you again. We appreciate your time and the Academy's interest and especially that you guys were one of the top three reporters, meaning the ophthalmologists.

So thank you and kudos to you all.

William Rich: Okay, thanks again.

Bye-bye.

Daniel Green: Bye.

(Sue Visherelli): Bye.

Natalie Highsmith: (Jennifer) can you tell us how many people joined us on the phone lines today?

Operator: Three hundred eighty-nine.

Natalie Highsmith: ...eighty-nine. Thank you everyone.

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

END