### PRESIDENT’S MESSAGE

By Sandy Silverman, MD

As we enter 2014 Interventional Pain Medicine faces another barrage of challenges from both the federal and state levels.

#### Federal Challenges

As most of you are aware, CMS implemented deep cuts to office-based epidural steroid injections. These took effect March 1, 2014. The final rule has significant rather devastating draconian cuts of 36% for physician payment in a facility setting and 58% for the procedures performed in an office setting (CPT 62310, 62311, 62318, 62319).

Simultaneously, the hospital outpatient rule showed increased payment for lumbar epidural injections from $565.75 to $669.91 for the exact same Epidural, an increase of 18.4%, which is a much higher level than any other setting from 2013. While previous hospital payments were 3-4 times higher than the in office reimbursement, now they are now 19 to 21 times higher.

FSIPP is working closely with ASIPP on this issue. While we have little direct effect on federal legislation, we are actively pursuing our Senators and the FMA (through our lobbyists) to support our position that these cuts are draconian, illogical, and will simply reduce access while INCREASING costs to the taxpayer. We believe that the RUC committee’s recommendations should be followed; that no cuts be implemented for these procedures by CMS. Clearly, CMS and the Obama administration have other ideas and their own agenda. This issue will likely not be resolved until 2015.

#### State Challenges

**SCOPE OF PRACTICE**

The Florida House has proposed new scope of practice changes which will affect all of medicine. Basically, the perceived lack of access (not enough physicians) due to large numbers of patients being insured through Obamacare has prompted sweeping new proposals that will allow nurse practitioners and other mid-level providers to greatly expand their practice. The Senate also has a companion bill which deals mostly with controlled substance prescribing, by Nurse Practitioners. We will be watching this quite closely and adamantly defending pain medicine as the practice of medicine.

**MEDICAL MARIJUANNA**

Medical marijuana has come to Florida. Floridians are now faced with proposed legalization for medical marijuana, as a constitutional amendment. Medical marijuana is so popular in Florida that 78 percent of likely voters in Republican-controlled state Senate districts back the idea, according to a recent state GOP poll obtained by The Miami Herald. HB 843 and SB 1030 have been filed proposing legalization of the so called Charlotte’s Web cannabis, a strain low in THC but high in Cannabidiol, which has alleged success in treating intractable seizures in children. However, there are still proponents of medical cannabis which has high levels of THC for a variety of medical illnesses or “any condition that the physician deems appropriate.” The implications of this bill are significant for the pain practitioner who utilizes controlled substances in their practice. Currently we must implement

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significant risk mitigation strategies regarding addiction, misuse and the use of multiple controlled substances. FSIPP will be monitoring the progress of the medical marijuana bill. We will also be presenting the subject at our annual meeting on May 16-18, 2014 in Orlando.

**Medicare CAC (Carrier Advisory Committee) Activity**

FSIPP is represented on the First Coast Service Options CAC. We have been very active in the past and continue to advocate interventional pain medicine and address any proposed coverage determination. For example, there is a Local Coverage Determination (LCD) for urine drug testing services that negatively impacts our ability to order sample confirmation testing or other essential requirements for urine screening. We are working diligently to prevent these changes in medical necessity from occurring in Florida. We all understand the necessity of utilizing urine drug testing in managing the pan-endemic of prescription drug abuse and doctor shopping. The prohibition of these confirmatory tests will make the safe management of opioid prescribing more difficult.

**Florida Supreme Court Bans Cap on Non-economic Damages in Medical Malpractice Cases**

The Florida Supreme Court just announced, in a 5-2 decision that financial caps on non-economic damages due to medical negligence are unconstitutional. All physicians in the state of Florida must now be prepared for a significant rise in their malpractice premiums. The FMA has worked hard on this issue and the general consensus is that the caps have kept premiums low and significantly reduced the burden of malpractice litigation. The Supreme Court decision potentially reverses all of the good that came from these efforts.

**FSIPP Annual Meeting and Workshops**

This year, FSIPP have its annual meeting and workshops May 16-18, 2014 at the Hilton Bonnet Creek in Orlando Florida. On Friday, May 16, we will be having 2 parallel workshops; Controlled Substance Management and Practice Management. The addition of Practice Management should prove very useful to physicians and their administrators. Topics of interest will include: ICD - 10, PQRS, Audits, HIPPA requirements and more. Please visit our website http://fsipp.org to see the schedule of events. As usual, the annual meeting will include national speakers on a variety of topics that will pique the interest of any pain physician.

Our 2015 will be truly unique in that we will be collaborating with ASIPP for a joint meeting in Orlando at the Lowes Royal Pacific Hotel. Stay tuned for details regarding this event.

Sincerely,  
Sandy Silverman, MD  
President, FSIPP
Don’t miss this year’s FSIPP Annual Meeting. It is expected to supersede all other meetings and includes an additional full-day Friday Schedule with concomitant sessions, Session A, Prescribing Controlled Substances and Session B, Practice Management. Our full-day Practice Management Session is a new edition to our meeting and will include: ICD-10, PQRS, HIPPA and cyber situations, audits, efficiency, solvency and much more. Our Controlled Substance Workshop will provide full updates on the pill mill crisis in Florida, a review of current statistics, trends in prescribing practices and addiction. The Friday Night Dinner for you and your family will feature Spanish Guitar Music, Flamenco Dancers, Sketch Artists and a Banquet Dinner. Discounted packages for the Spectacular Disney World Kingdoms are available to all. Lectures on Saturday and Sunday will be presented by nationally recognized speakers on cutting edge issues in pain management.

Go to FSIPP’s conference homepage, http://fsipp-conference.com, for information on reserving your hotel room. The Conference Brochure with registration materials will also be available soon and you will be notified.

Contact Executive Director Lorry Davis for further information.

See you there!

A Triumph of Contemporary Design within this Orlando Hilton

It’s all here at Hilton Orlando Bonnet Creek - a culmination of nearly nine decades of Hilton hospitality, experience and personalized service, lovingly presented in an Orlando resort that reaches above and beyond. Orlando’s newest AAA 4-Diamond hotel is located near Walt Disney World® Resort and is nestled on a 482-acre nature preserve. Our resort amenities include 12 dining and lounge options, lagoon-style pool with lazy river, complimentary deluxe transportation to and from the Walt Disney World® Theme Parks, and adjacent Waldorf Astoria Spa® and championship golf club. A world-class convention center boasts 150,000 square feet of function space, providing full meeting and event services.

The 1,001 guest rooms and suites are restful, private retreats with outstanding amenities and services provided by our professional staff. The cuisine explores new dimensions, tempting the palate with irresistible creations. An equally sublime, but entirely different sort of experience awaits at the exclusive Waldorf Astoria Spa®. Or play an inspired round of golf on the beautifully serene Rees Jones-designed course. Swim in the free-form lagoon-style pool with water slide.
Urine Drug Testing, FSIPP Position Statement
By Larry Dalton, DO, FSIPP President-Elect

The Florida Society of Interventional Pain Physicians strongly opposes the implementation of the proposed LCD “Testing for Drugs of Abuse”. Limiting the frequency and scope of specimen validity testing will compromise the safety of the beneficiaries in our coverage area. Florida has been the center of prescription drug abuse for the nation, with seven people dying per day due to prescription drug overdose at its peak. The implementation of the Prescription Drug Monitoring Program (PDMP), as well as new Florida laws to regulate the prescription and distribution of controlled substances has significantly reduced the prescription overdose deaths. However, there are still at least 5 overdose deaths daily in Florida.

Point of Service (POS) testing is an important tool for Pain Physicians but has severe limitations. The rates of false positives as well as false negatives are high. POS testing often does not include many of the synthetic medications which are utilized to treat pain. High complexity testing Liquid Chromatography and Mass Spectrometry (LC/MS) is an invaluable tool to minimize the issues with the POS testing, but also allows practitioners to test for multiple specific medicines which may be present.

A recent Harvard study published in the BMJ\(^1\) has shown that 34.7% of Medicare part D beneficiaries are taking opioids, 40.6% of which were obtained from more than one provider. This came as a surprise to the authors who had anticipated a rate of about 10%. The study did not take into account how many of these patients were also taking other controlled substances and the additional providers involved.

It is essential for us as clinicians to know not only what medications have been filled at the pharmacy (which the PDMP gives us) but more importantly, what medications are in the patients system. Self reporting is not accurate in this patient population, and urine drug testing with a robust testing panel is a necessary tool to ensure the patients safety.

Medicare Contractors must also consider the geographical and cultural variances within our state. Large urban areas such as South Florida, Tampa, Orlando and Jacksonville contain a greater risk for prescription drug abuse simply due to the greater number of prescribers compared to more rural communities. Florida is also unique in that it has a large seasonal population from other states, which complicates testing since Florida physicians often do not have access to other states PDMPs. Limiting the scope or frequency of these testing tools puts Medicare beneficiaries at risk of drug-drug interaction as well as overdose.

The Florida Society of Pain Physicians is strongly opposed to this proposal and requests that First Coast Service Options to withdraw this LCD from consideration.

References
Maintenance Of Certification Anesthesia (MOCA) In Sub-specialties
By Deborah H. Tracy, Md, Mba, Editor

The ABA is changing its policies and protocols for recertification in all areas including pain. More emphasis will be placed on MOCA (Maintenance of Certification). Over a 10 year period those of us who have sub-specialty pain certification from the ABA will have to get 90 self assessment CMEs and 20 Safety CMEs, either thru the ASA or a Society that is credentialed by the ABA. Then certain CMEs provided at your meetings and otherwise would be recognized as part of the total 110 (90 + 20) required by the ABA for MOCA over ten years. To maintain MOCA the physician would also need 140 Category 1 CMEs for a total of 250 over 10 years. The examinations will be phased out and or will require MOCA as part of the recertification process. For more information contact the ABA at (866) 999-7501 or via email at COMS@theABA.org.

This year CMS gave an additional 0.5% bonus on total Medicare revenue per practitioner if the physician was participating in MOCA (2013) by their specialty Board.

ICD-10
Approximately 14,000 ICD-9 Codes will become ~140,000 ICD-10 Codes. ICD-10 starts October 1, 2014 and there is no delay in sight. The October 1 date does not refer to the date you submit your claim, but rather to the date of service (DOS). On the 1500 form, if the DOS in the field is 10/1/14 or later, and you use any ICD-9 code, the claim will be returned and denied. You cannot mix ICD-9 and ICD-10 codes. Use only ICD-10 codes.

You will need to do some testing to make sure the time calculations will work. Contact your Clearing House, if you use one, and begin testing with them, be sure that they are capable and confident in their readiness for the October date. Do the same with your Billing Software Company.

Create a new Superbill so that your diagnoses are translated to the new ICD-10 codes. The FSIPP Annual Meeting, Practice Management Workshop, will include a full session on ICD–10 Codes with Marvel Hammer, for Pain Management and we will provide a sheet of codes most often ones used in pain management. This Workshop should allow you to:
1. Understand how to convert ICD-9 codes to ICD-10 codes
2. Learn to use the ICD-10 Coding Book
3. Identify the symbols, digits, placeholders, color coding, footnotes in the Coding Book
5. Ask the Coding Expert difficult questions
For the most part, there has been a steady decline in medical malpractice payments across the United States since 2003. In 2013, however, the total amount increased 4.7% to roughly $3.7 billion when compared to 2012, according to the National Practitioner Data Bank (NPDB). Regardless, the average amount of individual malpractice payments nationwide has held relatively constant. In Florida, the total indemnity paid by medical malpractice insurance carriers dropped 29% in 2012 in comparison with the previous reported year according to the 2013 Florida Office of Insurance Annual Report. This amounts to a drop from $625,984,821 in 2011 to $439,166,594 in 2012.

Tort Reform

There may be several factors contributing to these numbers. Tort reform across the United States has made it difficult for patients to pursue frivolous malpractice claims in the courts and has resulted in fewer lawsuits. Plaintiff firms are limiting their financial exposure and are more likely to take on the most egregious cases of potential negligence. Currently, non-economic damages cannot exceed $500,000 per plaintiff and no practitioner defendant is liable for more than $500,000 in non-economic damages, unless it is a catastrophic case. The total non-economic damages recoverable from all plaintiffs against all practitioners cannot exceed $1,000,000. The caps were enacted in 2003 as a response to soaring malpractice insurance rates in Florida. According to a report by Deloitte & Touche LLP, the legislation had an impact of a 7.8% decline in rates in 2004, of which 5.3% was directly attributed to the caps.

Frequency & Severity

According to the Florida Office of Insurance Regulation 2013 Annual Report, there were 2,491 closed medical malpractice claims reported in 2012. This number has been relatively flat the past three reporting years (2,520 in 2010; 2,461 in 2011). The severity of the injuries reported (Severity Class 9 – Death) has gradually been decreasing in Florida, which insurance carriers attribute to effective tort reform, including a 90-day presuit period and a required expert affidavit when attempting to pursue medical malpractice claims against practitioners. The tort reform also includes the caps on non-economic damages. Medical malpractice insurance premiums have also seen a downturn with overall premium in Florida dropping roughly 5.6% from 2011 to 2012.

Tort Reform Going Forward: The Estate of Michelle McCall vs. U.S.A.

The case currently challenging the non-economic caps involves an Air Force dependent who received prenatal care at a United States Air Force clinic. She had a complicated delivery that resulted in her demise. The McCall family sued in federal court and the court ruled for actual damages of $1,000,000 and non-economic damages totaling $2,000,000. However, the court lowered the non-economic damages to $1,000,000 due to Florida’s medical malpractice statute limiting caps on non-economic damages. This ruling was ultimately appealed to the Florida Supreme Court. The court heard oral arguments on February 9, 2012. In the two years since the arguments were heard, the Florida Supreme Court has still yet to rule on whether it will uphold the non-economic damage caps.

The McCall opinion is expected in the near future. If the court does not uphold the caps, the end result could include increased reported medical malpractice claims and varying severity. This could potentially have an adverse effect for practitioners due to an increase in medical malpractice insurance premiums across the board.

Jason Haynie is a Claims Representative for Florida Doctors Insurance Company. He is a licensed claims adjuster, and works with FLDIC insureds and defense attorneys on the investigation, defense, and resolution of claims. Jason has worked in the insurance industry for over 17 years.
What's New In Interventional Pain For 2014
By David Vaughn, Esq., CPC

The following constitutes my analysis of the highlights of what's new and what's not new in the interventional pain arena for 2014.

1. Reimbursement.

a. Conversion Factor. The Medicare Fee Schedule Final Rule (“Final Rule”) initially reduced the conversion factor (“CF”) for surgical procedures and E&M services by 20.1% before Congress stepped in and passed the Pathway for SGR Reform Act of 2013, which President Obama signed on December 26, 2013, and which eliminates the SGR cuts and actually increases the CF by 5.3%, at least until March 31, 2014, when Congress is supposed to pass a final SGR fix. The CF is now $35.8228, instead of last year’s $34.0230.

b. Massive Epidural Reimbursement Cuts. Despite the reversal of the SGR cut, “regular” (translaminar) epidurals are taking a major cut, especially in the office setting (POS 11). In the office setting, the reductions are: 62310 – $146.64; 62311 – $108.53; 62318 – $134.39; and 62319 – $64.41. These cuts resulted from reductions in both the PE (practice expense) and wRVU (work value) made by CMS. If you perform your injections in the hospital outpatient department or in an ASC, the cuts are less, but still material, as follows: 62310 will be reduced $39.80; 62311 will be reduced $20.75; 62318 will be reduced $34.36; and 62319 will be reduced $19.74. All amounts are national, unadjusted for geographic locality, and all are based on the 2013 CF and do not take into account the 5.3% increase in the CF for the first 3 months of 2014.

c. Stimulator Trials. Stimulator trials may not be profitable any longer in the office setting. Medicare now bundles payment for the leads (L8680) into payment for the procedure pro fee (CPT code 63650). While CMS materially increased the reimbursement for 63650 to purportedly cover the price of the leads, the increase was not significant enough to make payment for the trial profitable in the office. 63650 now pays $1,281.65 for the entire service of placing the first lead (including the cost of the lead), and $1,922.47 for two leads (63650 + 64650-51; based on 2013 CF; increase by 5.3% for 2014 CF). One can no longer bill Medicare separately for L8680 x 4, 8, or 16. Having said that, this is Medicare, and we cannot predict at this juncture whether other payers will follow suit. (For commercial payers, the 2014 HCPCS II Code still contains L8680 as a code, but as to Medicare, the latest version of CMS’s DME fee schedule omits L8680.)

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d. Reimbursement for Transforaminal Epidurals and Facet Blocks in 2014. Reimbursement for transforaminal epidurals in 2014 will decrease in the office setting between 5.5%-7.9%. In the facility, the decrease will be between 2.2%-3.8%. Reimbursement for facet blocks in the office setting will decrease between 5.9% and 7.8%. In the facility, reimbursement will decrease between 2.2%-3.7%.

2. Coding.

a. E&M Codes. Insofar as E&M coding is concerned, code descriptors remain the same for new patient visits, established patient visits, consults, initial hospital care, and subsequent hospital care. There are new codes for telephone and internet consultations between a requesting physician and a consulting physician. While the requesting physician bills his/herservice via the prolonged E&M service codes, the consulting physician bills new codes 99446-99449, depending on the number of minutes spent in consultation.

b. Critical Care for Neonates. There are two new critical care codes for neonates, 99481 (total body hypothermia) and 99482 (selective head hypothermia).

c. Procedure Codes. Code descriptors remain unchanged for the core interventional pain procedures, i.e., TPI, SIJ injections, translaminar and transforaminal epidurals, facet blocks and RF, pumps, pump refills, stims, vertebroplasty, and kyphoplasty. However 64613 (destruction, neck muscle) was deleted and replaced by 64616, and a new set of codes (64643-47) was added for destruction of muscles in the extremities.

d. Radiological Codes. Code descriptors for fluoroscopic guidance (77002, 77003) and ultrasound (76942) remain unchanged, although 77002 contains a clarification that if you are billing for an arthrography interpretation, 77002 is bundled. Similarly, 76942 contains a parenthetical that ultrasound cannot be billed with about 15 different codes, including the facet and transforaminal epidural codes that require fluoroscopy or CT. The discography and epidurography codes remain unchanged as well.

e. UDS, PT, Moderate Sedation, and Modifiers. The code descriptors for urine drug screens, moderation sedation, physical therapy, and the various CPT Code modifiers used by interventional pain remain the same.

3. PQRS.

a. Two Different “Buckets.” In analyzing the rules for PQRS for 2014, one must distinguish between two separate PQRS “buckets”: (1) the .5% incentive payment bucket (the “Incentive”), and (2) the 2% penalty bucket (the “Penalty”). The rules are different for each, so you have to keep in mind the particular bucket with which you are dealing when analyzing the rules, or else you can easily confuse the rules for one bucket as being applicable to the other bucket.

b. The Incentive Bucket. If you want to capture the Incentive for 2014, you must report 9 measures (not 3) from at least 3 NQS domains (not 1).

c. MAV Audit Process for Less than 9 Measures. If you continue to report only 3 measures (or any number less than 9), you are subject to the MAV audit process that allows CMS to audit you to verify whether you could have reported more than 3 measures and more than 1 domain. If CMS determines you could have reported more measures and domains than you did, CMS will reclaim the incentive.

d. 50% of Claims. For each measure, each eligible professional (“EP”) must report that measure for 50% or more of the claims for which that measure is applicable.

e. The 6 NQS Domains. The 2014 Final Rule contains about 100 pages listing each PQRS measure and the NQS “domain” to which each measure has been assigned. You should download the Final Rule and print out the measures (continued next page)
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and their domains if you intend to capture the Incentive. The 6 NQS domains, to which all PQRS measures are assigned, are: (1) Person and Caregiver-Centered Experience and Outcomes; (2) Patient Safety; (3) Communication and Care Coordination; (4) Community/Population Health; (5) Efficiency and Cost Reduction; and (6) Effective Clinical Care. So, if you are trying to capture the Incentive, you should be reporting measures from 3 of these domains (unless there are less than 3 domains which apply to you, in which case, you are subject to the MAV audit process).

f. The Penalty Bucket. If all you are concerned about in avoiding the 2% penalty, then you can continue to report only 3 PQRS measures during 2014. This will result in the avoidance of the 2% penalty in the 2016 payment period. (The penalty is assessed 2 years after the reporting period.) Why don't you have to report 9 measures from 3 domains to avoid the penalty, just like you have to report to receive the Incentive? CMS advises that 2014 will be a grace period, but that beginning in 2015, CMS intends to require the reporting of 9 measures from 3 NQS domains in order to avoid the 2% penalty in the 2017 payment period.

g. Cannot Report Measures Groups via Claims Reporting. There is a Back Pain Measures Group that some of you have been reporting on your 1500 claims. You can no longer use the 1500 claims to report PQRS group measures, such as the Back Pain Measures Group. You can, however, still use the 1500 form to report individual measures, but not group measures. CMS states the following in the Final Rule, “However, we do not believe it is necessary to maintain this reporting option, because an eligible professional may still use the free option of claims-based reporting to report individual quality measures for the 2014 PQRS incentive. In addition, we note that, while many qualified registries change a fee for use of the registry, not all registries may change a fee.” So, you can still use the 1500 method to report individual measures, just not group measures, or you can join a registry to report the group measures.

4. The Value Based Modifier. The Value Based Modifier (“VBM”) has its own set of incentives and penalties, separate and apart from PQRS.

a. Penalty vs Incentive. Again, one must distinguish between the Incentive bucket and the Penalty bucket.

b. Reporting Period vs Incentive/Penalty Period. For the VBM the Incentive and the Penalty are assessed two years after the data is reported. So, 2014 reporting results in an Incentive or Penalty in 2016.

c. Amount of Incentive/Penalty. The amount of the Penalty and/or Incentive ranges anywhere from minus 2% to plus 2%. In 2014, if you don’t register and don’t report appropriately, the penalty is automatically 2%. Even if you do register and do report, you can still lose up to 2%, although you can also earn up to 2%, as discussed more in depth below. The VBM penalty is in addition to the PQRS penalty, so if you do not report for either program, you will suffer a 4% penalty on your Medicare income.

d. Group Sizes. The VBM rules differ depending on the size of your group. There are 3 group sizes, and the year in which you must start registering and reporting measures for the VBM differs depending on your group’s size. If your group has 100 or more eligible professionals (“EP’s” - which includes CRNA’s, NP’s, and PA’s), you should have registered in 2013; if you did not, you will suffer a penalty in 2015, 2 years after the 2013 reporting period. (Note that the penalty in 2015 for the 2013 reporting period is limited to 1%; whereas, it is 2% beginning in 2014.) If you are in a group with 10-99 EP’s, you must report in 2014 to avoid the penalty in 2016; if you are in a group of less than 10 EP’s, you will have to report in 2015 to avoid the penalty in 2017.

e. Counting EP’s vs Paying/Penalizing EP’s. Although CRNA’s, PA’s, and NP’s count toward determining whether a group has 100 or more EP’s (or 10-99 EP’s), the VBM Incentive/Penalty is only paid/assessed to/against physicians.
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f. Quality Tiering. Quality-tiering is the process of comparing your group with other groups in your specialty insofar as quality measures and costs are concerned. Depending on how you compare to other groups, you could receive anywhere from a 2% Penalty to a 2% Incentive. So, for example, if your quality measures rank high and your costs rank low compared to your peers, you earn a 2% incentive; if your measures are low and your costs are high, you are penalized 2% of your Medicare income for the year. Unlike PQRS, in which payment is for mere reporting, the VBM program is true payment for performance. So, even if you report, you can still get penalized under the quality-tiering methodology if your measures are poor and your costs are high compared to your peers.

g. Timing of Quality-tiering. For the 2014 reporting period, groups of 100 or more EP’s cannot elect to avoid quality-tiering, i.e., even if they register and report, they can still lose up to 2% if they have poor measures and high costs. Groups of 10-99 EP’s must still register and report, but they receive a one-year grace period during the 2014 reporting period whereby they may receive the incentive in 2016, but not the Penalty in 2016, since this will be their first year in the VBM program. The grace period for groups of 10-99 only lasts one year. A group subject to quality-tiering can end up with the following incentives/penalties: +2%, +1%, 0%, -1%, and - 2%, depending on how their measures and costs compare nationally to their peers.

h. Cost Measures. As indicated above, the Incentive/Penalty amounts are calculated on a combination of quality measures and costs. As to costs, there are 6 cost measures by which groups in the same specialty are compared. They are: (1) total per capita costs for beneficiaries; (2) total per capita costs for patients with diabetes; (3) total per capita costs for patients with coronary heart disease; (4) total per capita costs for patients with COPD; (5) total per capita costs for patients with heart failure; and (6) Medicare spending per patient in an acute inpatient stay.

i. The GPRO Requirement. “GPRO” stands for “Group Practice Reporting Option.” This was created in 2010 as one method by which a group could report PQRS measures. Most groups have elected to report by claims and not by the GPRO. Now, however, GPRO is critical for the VBM. Although last year large groups could choose to register via the Administrative Claims process and avoid reporting via the GPRO. This year the Administrative Claims process is no longer available, and in order to avoid the 2% Penalty, the regulations provide that each group (i.e., groups of 100 or more EP’s and groups of 10-99 EP’s) must “selfnominate for the PQRS GPRO and meet the criteria as a group to avoid the PQRS payment adjustment, and 50% of the EP’s in such group [must] meet the criteria as individuals.” 42 CFR 414.1270. I interpret this to mean that even if a group of 100 or more EP’s registered under the Administrative Claims option in 2013, the group must self-nominate under the GPRO in 2014 and meet the criteria as a group. A group can report the GPRO measures either by signing up with a Registry (which typically charges a fee), or via CMS’s GPRO Web Interface. If you go to the PQRS section of the CMS website, there are several downloads available explaining the GPRO methodology and measures.

j. What Measures to Report. Since the Administrative Claims reporting method is no longer available in 2014, most of you will be reporting via the GPRO Web Interface. The measures you have been reporting for PQRS are not the same measures you will need to report via the GPRO Web Interface for the VBM. While the VBM uses the PQRS measures, the GPRO measures are different from the individual measures you have been reporting. The CMS website regarding the GPRO Web Interface reporting process states the following:

i. “PQRS GPRO MEASURES USING THE WEB INTERFACE. For purposes of determining whether a group practice participating in GPRO satisfactorily submits PQRS quality measures data for 2014, each group practice participating in the 2014 PQRS Web Interface GPRO reporting method will be required to report 17 quality measures (22 individual measures when accounting for the two composite measures). A list of the 22 2014 GPRO Web Interface GPRO reporting method measures can be found in the [documents listed in the download section of the website].”

ii. Naturally, when you look in the Downloads section, only 2013 documents are there, and the 2014 documents haven’t been posted yet. So, you will need to check back and download those measures and the instructions.

k. Help with Questions. CMS has hired a contractor to provide help with your questions. QualityNet has a phone number, 866.288.8912, and an email, Qnetsupport@sdps.org. Believe it or not, they are responsive. I have called and emailed them in the past. I encourage you to contact them if you have any questions.

5. Conclusions. For most groups the most important changes this year relate to the procedure reimbursement reduction and the VBM reporting requirements.