

E-Prescribing (eRx) Incentive Program

Presented by Cohen Healthcare Consulting

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Background

- eRx is the transmission of prescription(s) through electronic media (NOT fax).
- The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 mandated that all plans and pharmacies participating in the Medicare prescription benefit (part D) support an electronic prescription program.
- Pilot programs established that eRx had proven potential to reduce medication errors and cost of medical care.
- 2009 eRx Incentive is initiated.

Facts on eRx

- Reporting periods are one year in length; years 2009-2013 (*this is similar to PQRS*).
- Incentive amounts: based on the Secretary of Health and Human Services' estimate of the allowed charges for all such Physician Fee Schedule (PFS) covered professional services provided by the eligible professional during the reporting period.

Facts on eRx

- Incentive Amounts

- 2011 = 1.0%

- 2012 = 1.0%

- 2013 = 0.5%

- 2014 = incentive is over

Example	
Total Medicare Part B Charges submitted	\$200,000
Total Medicare Part B Allowed Charges	\$100,000
Total Medicare Part B Payments Received	\$70,000
Total estimated 2011 incentive (\$100,000 x 1%)	\$1,000

Facts on eRx

- Incentive payments are issued separately as a single consolidated payment in the following year.
- Payment issued to the first valid group location listed under the Taxpayer Identification number (TIN), or for solo practitioners, to the first valid practice location listed under the TIN.
- Carrier/MAC will make the payment electronically or via check (based on how they normally receive payment).

Facts on eRx

- Limitations – incentive does not apply:
 - If the Medicare allowed charges for all covered professional services for the codes (visit codes) to which the eRx measure applies are < 10% of the total allowed charges under Medicare part B for all such covered professional services provided by eligible professional **-OR-**
 - If determined that the eligible professional does not submit (including both electronic and non electronic) a sufficient # of prescriptions under part D.
 - Although there is no requirement that providers write prescriptions electronically, in the Medicare Prescription Drug Benefit final rule, Part D sponsors who participate in the Part D program are required to support and comply with electronic prescribing. Providers that prescribe or dispense Part D drugs are required to comply with the final standards only when prescription information or certain other related information is electronically transmitted.

Incentive programs

	Can I be in?		
If I am in incentive program:	PQRS	EHR	eRx
PQRS	NA	Yes*	Yes*
EHR	Yes*	NA	Yes*
eRx	Yes*	Yes	NA

**Providers participating in PQRS cannot earn both an eRx incentive and an EHR incentive in the same year if the provider elects to receive their EHR incentive payment through Medicare. You still must report eRx to be exempt from the payment adjustment.*

eRx eligibility

- An individual eRx prescriber, eligible to receive an incentive payment, must generate and report one or more eRx's associated with a patient visit, a minimum of 25 unique visits per year.
- Each visit must be accompanied by the eRx G code (G8553) attesting that during the patient visit, at least one prescription was electronically prescribed.

eRx eligibility - GPRO

- Participation in the eRx Incentive Program, either as an individual eligible professional or under the eRx GPRO (Group Practice Reporting Option), is voluntary for group practices participating in the Physician Quality Reporting System GPRO;
- However, CMS requires that for a group practice to participate in the 2011 eRx GPRO, it must comply with all requirements for participation in the Physician Quality Reporting System GPRO and be participating in the Physician Quality Reporting System GPRO for 2011.

eRx eligibility - GPRO

- A group practice that wishes to participate in both the Physician Quality Reporting System GPRO and in the eRx GPRO, must notify CMS of its desire to do so when self-nominating for the 2011 Physician Quality Reporting System GPRO.
- When a group bills, the group NPI is submitted at the claim level, therefore the rendering NPI must be placed on each line item, including all allowed and quality data line items.
- an individual eligible professional who is a member of a group practice selected to participate in the eRx GPRO is not eligible to separately earn an eRx incentive payment as an individual eligible professional under that same Tax Identification Number (TIN) (that is, for the same TIN/National Provider Identifier, or NPI, combination). Once a group practice (TIN) is selected to participate in the GPRO, this is the only method of eRx reporting available to the group and all individual NPIs who bill Medicare under the group's TIN.

Eligible professionals

- **Eligible professionals do not need to participate in the Physician Quality Reporting System to participate in the Electronic Prescribing (eRx) Incentive Program.**

Eligible Professionals (and able)

1. Medicare physicians

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic

2. Practitioner

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
(and Anesthesiologist Assistant)
- Certified Nurse Midwife
- Clinical Social Worker

2. Practitioner (continued)

- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologists

3. Therapists

- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist

Note: Eligible professionals must have prescribing authority in order to participate in this program

Eligible but not able

- The following professionals are eligible to participate but are not able to participate for one or more reasons:
 1. Professionals paid under or based upon the PFS billing Medicare Carriers/ Medicare Administrative Contractors (MACs) who do not bill [Medicare] directly.
 2. Professionals paid under the PFS billing Medicare fiscal intermediaries (FIs) or MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level *(as follows)*:

Eligible but not able

- Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI for the professional services provided by the physician or practitioner.
- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.
- Services payable under fee schedules or methodologies other than the PFS are not included in Physician Quality Reporting (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

Why start now

- Eligible professionals do not have to enroll or file an intent to participate in the eRx Incentive Program.
- Professionals who choose to participate by reporting the eRx measure through claims can simply report the G-code on service lines of Medicare Part B Physician Fee Schedule (PFS) professional-services claims.

Why start now

- Beginning with 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment.
- Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 authorizes CMS to apply this adjustment regardless if the eligible professional is planning to participate in eRx Incentive Program.

Why start now

- With regards to all of the eligible professionals' Part B covered professional services, the payment adjustment will result in the eligible professional or group practice receiving a percentage of the Physician Fee Schedule amount normally received:
 - 2012 99%
 - 2013 98.5%
 - 2014 98%

Why start now

- CMS will analyze claims data from January 2011 to June 30, 2011 to determine if the eligible professional has submitted at least 10 claims electronic claims in the first 6 months of calendar year 2011. You may start now.
- Group practices reporting as a GPRO I or GPRO II must report all of their required events in the first 6 months to avoid the payment adjustment.

Why start now: exemptions

- If an eligible professional wishes to request an exemption to the eRx program and payment adjustment, there are two “hardship” codes that can be reported via claims:
 - G8642 - practice in a rural area without sufficient high speed internet access
 - G8643 - practice in an area without sufficient pharmacies for eRx

Why start now: exemptions

- There is also a G code to indicate that the eligible professional does not have prescribing privileges.
 - G8644

How to start

- 2011 reporting options
 - To report this quality measure, a qualified eRx system must have been adopted.
 - A qualified eRx system is one that is capable of ALL of the following:
 - Generation of complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBM's) if available.
 - Select medications, print prescriptions, electronically submit prescriptions, and conduct all alerts.
 - Provide information related to lower cost, therapeutically appropriate alternatives.
 - Provide information on formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

How to start

- To report this measure via claims reporting, the patient visit must have a denominator CPT code and the numerator G-code on the claim.
 - Numerator G code=G8553
 - Meaning at least one prescription created during the encounter was generated and transmitted electronically using a qualified system.

How to start

Denominator criteria: patient visit during the reporting period (CPT or HCPCS).

90801, 90802, 90804, 90805, 90806, 90807, 90808,
90809, 90862, 92002, 92004, 92012, 92014, 96150,
96151, 96152, 99201, 99202, 99203, 99204, 99205,
99211, 99212, 99213, 99214, 99215, 99304, 99305,
99306, 99307, 99308, 99309, 99310, 99315, 99316,
99324, 99325, 99326, 99327, 99328, 99334, 99335,
99336, 99337, 99341, 99342, 99343, 99344, 99345,
99347, 99348, 99349, 99350, G0101, G0108, G0109

How to start

- Measure reporting via registry:
 - A denominator CPT code and an electronically generated and transmitted prescription (NOT faxed) are reported.
 - Professionals participating in a registry that self-nominates and qualifies to submit data on behalf of eligible professionals for a program year should expect to receive more information from the registry on how to participate. Only registries qualified for the Physician Quality Reporting Initiative (PQRI) are eligible to become qualified for purposes of submitting data on the eRx measure on behalf of eligible professionals.

How to start

- You may also report using EHR
 - To qualify to report the eRx measure for 2011, EHR vendors will need to be qualified to report 2011 PQRI EHR measures. EHR vendors who wish to qualify to participate in the 2011 PQRI EHR program must have submitted a self-nomination letter requesting inclusion in the 2011 PQRI Testing Process in 2010 no later than January 31, 2010. You may find eligible 2011 vendors in the down load section of this link.
 - https://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage

Claim example

- The eRx G code must be submitted with a line item charge of \$0.00 at the time the associated service (denominator) is performed.
- If the system does not allow for 0 charge, you may enter a nominal charge such as \$0.01.
- The eRx line item will be denied for payment, but are passed through claims processing system to the National Claims History database. Eligible professionals will receive a remittance advice which includes N365. (meaning this is not payable, it is for reporting purposes only)

Claim example

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE					ORIGINAL REF. NO.									
1. 7 14 .00										3. [REDACTED]														
2. 250 .00										4. [REDACTED]					23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #			
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER																
01	10	11	01	10	11	11	99202				1	45.00					NPI	0123456789						
01	10	11	01	10	11	11	G8553				1	0.00					NPI	0123456789						
																	NPI							
																	NPI							
																	NPI							
																	NPI							
25. FEDERAL TAX I.D. NUMBER					SSN EIN		26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back)					28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
XX-XXXXXXX					<input checked="" type="checkbox"/>		XXXXX					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					\$ 45.00		\$		\$ 45.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #				
SIGNED										DATE										a. [REDACTED]				

PHYSICIAN OR SUPPLIER INFORMATION

Price @ \$0.01 if you must have a price.

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the eRx calculations.

Keep in mind

- If you are submitting the HCPCS codes (any of the G codes), you must see this on your EOB to verify that Medicare is processing the codes.
- If it is not on your EOB, you are not getting credit.
- You will receive the incentive payment for 2011 in the beginning of 2012.

FAQ's

- **Based on the individual eligible professional's experience in their practice, will those eligible professionals be subject to the payment adjustment.....**
- Published 02/03/2011 02:29 PM | Updated 02/08/2011 04:35 PM | Answer ID 10408
- Based on the individual eligible professional's experience in their practice, if more than 10% of an eligible professional's total Medicare Part B PFS charges are comprised of charges from the electronic prescribing (*eRx*) measure's denominator and (s)he has 100 eligible *eRx* visits containing an encounter code in the *eRx* measure's denominator, but does not write the 10 electronic prescriptions and report via claims only by June 30, 2011 as required for exemption from the 2012 Payment Adjustment, will those eligible professionals be subject to the payment adjustment?

Will an eligible professional be subject to the 2013 *eRx* Payment Adjustment if his/her total E/M charges represent more than 10% of his/her total allowed Part B PFS charges that are comprised of codes from the *eRx* measure's denominator, but (s)he does not write and report the required 25 electronic prescriptions via one method (claims, registry, or EHR) by December 31, 2011?

- In the scenarios provided, the eligible professional meets the criteria for each respective *eRx* Payment Adjustment and will receive the 2012 payment adjustment and will not be exempt from the 2013 payment adjustment based on the eligible professional's 2011 reporting (as per the 2011 Final Rule). The Final Rule states "Section 1848(a)(5) of the Act requires us to implement a payment adjustment beginning with covered professional services furnished by an eligible professional during 2012, if the eligible professional is not a successful electronic prescriber. We do not have the authority to delay implementation of this payment adjustment." (pg. 392, 2011 Final Rule at <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>)

Please note that that the 10 electronic prescriptions requirement to avoid the 2012 *eRx* Payment Adjustment must be completed using claims-based reporting.

The 25 electronic prescriptions requirement to avoid the 2013 *eRx* Payment Adjustment may be completed using claims-based reporting, registry-based submission, or EHR-based submission; however, all 25 must be completed through a single reporting method. Reporting a portion through more than one method (such as 10 via claims and 15 via registry) but totaling 25 will not count as meeting the requirement.

FAQ's

- **If claims submitted for services do NOT have PQRI or eRx QDCs on them, can the provider go back and resubmit them to include the QDCs?**
- Published 09/13/2007 10:49 AM | Updated 12/01/2010 11:06 AM | Answer ID 8678
- If claims submitted for services do NOT have Physician Quality Reporting Initiative (PQRI) or Electronic Prescribing Incentive Program (eRx) quality-data codes (QDCs) on them, can the provider go back and resubmit them to include the QDCs?
- No. Claims may not be resubmitted simply to add or correct QDCs. QDCs which supply the numerator must be submitted on the same claim that contains the denominator information (i.e., CPT Category I or HCPCS codes). Refer to the claims-based reporting principles delineated in the PQRI Implementation Guide available on the CMS website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage. See the Claims-Based Reporting Principles for the 2010 eRx Incentive Program available on the CMS website at http://www.cms.hhs.gov/ERxIncentive/06_E-Prescribing_Measure.asp#TopOfPage.

Resources

For additional information please look at:

<https://www.cms.gov/ERxIncentive>

-OR-

Quality Reporting Portal

1. QualityNet Help Desk – 7:00 AM – 7:00 PM CST

- General CMS Physician Quality Reporting System and eRx Incentive Program information
 - Portal password issues
 - Feedback report availability and access
 - PQRI-IACS registration questions
 - PQRI-IACS login issues

Phone: 1-866-288-8912

TTY: 1-877-715-6222

Email: Qnetsupport@sdps.org

2. A/B MAC and Carrier Provider Contact Centers

- Remittance Advice
 - Incentive payments
 - Adjustments made to incentive payments due to sanctions/overpayments
 - NPI-level feedback reports

Thank you

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