Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized an incentive program for eligible professionals who are successful electronic prescribers as defined by MIPPA. This program is separate from the Physician Quality Reporting System, also known as the PQRS Incentive Program, which was authorized by Division B of the Tax Relief and Health Care act of 2006 – Medicare Improvements and Extension Act of 2006 (MIEA-TRHCA).

The incentive program began on January 1, 2009 and each year the program is reviewed and changes implemented by CMS (the Center for Medicare and Medicaid Services) through the annual rulemaking process, usually as part of the Medicare Physician Fee Schedule (MPFS), and published in the Federal Register. The 2013 MPFS included updates for the 2013 eRx Incentive Program.

AHS compiled this eRx Incentive Program Resource Guide to assist our clients and staff in understanding the eRx program and presenting the program’s information in one place. We have summarized the program and also given you the CMS links for further information, which can be found in ADDENDUM A. You may also go directly to the CMS eRx Incentive Program website at https://www.cms.gov/ERxIncentive/ to obtain more information on this program.

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DEFINITIONS

For the purpose of this resource guide, the following abbreviations will be used to be in sync with CMS' literature and for simplification purposes.

EP – Eligible provider
Electronic Prescribing Event – all prescriptions electronically prescribed during a patient visit
E-prescribe(r) – electronic prescription/prescriber
GP – Group Practice

The following are descriptions of terms frequently used when describing eRx measures:

Numerator – eRx G code – G8553
Denominator – Qualifying CPT codes for the eRx program

2013 eRx Incentive Program - The Basics

The 2013 definition of electronic prescribing (eRx) – The transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, include an eRx network.

Electronic prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. Durable medical equipment (DME) and over the counter medications may be electronically prescribed for the purpose of this measure.

- Faxes initiated from the eligible professional’s office do not qualify as electronic prescribing.
- Electronically generated refills do not count as an e-prescription
- If a pharmacy is not able to receive prescriptions electronically, the use of a pharmacy that cannot receive an electronic prescription does not invalidate the eRx event and the eligible EP would still get credit for electronically prescribing as long as the EP reports this event for an eligible visit.

Highlights of the 2013 eRx Program:

- The incentive payment for the 2013 reporting period is 0.5% of the EP’s total estimated Medicare Part B PFS allowed charges for all covered professional services furnished by the EP during the respective reporting period.
• EPs do not have to participate in the PQRS program in order to participate in the eRx program but if the EP participates in the PQRS program and successfully reports other PQRS measures as well as the E-prescribe measure, the EP could earn 1.0% of his/her Medicare allowed charges for 2013. (0.5% for PQRS and 0.5% for eRx)

• Qualified providers who do not report via electronic prescribing in 2013, will receive a 2% reduction in their Medicare reimbursements for 2014.

• EPs may participate in the eRx Incentive Program:
  o As an individual EP; or
  o As part of the Group Practice Reporting Option (GPRO)

• Please see the Payment Adjustment section of this guide for information on EPs who do not have to report the e-prescribe measure and will not receive payment penalties.

Who May Participate in the 2013 eRx Incentive Program?

• The EP must be a physician, Nurse Practitioner or a Physician Assistant as of June 30, 2013. A complete listing of eligible providers is available in ADDENDUM B.

• 10% of the EP's Medicare Part B charges must be comprised of the 53 codes in the denominator of the measure for the EP to be incentive eligible. Eligible CPT codes are:

  o 90791 - 90839 – Psychiatric and psychotherapy
  o 92002 - 92014 – General Ophthalmological
  o 96150 - 96152 – Health & Behavior assessment
  o 99201 - 99215 – E & M Visit Codes
  o 99304 - 99316 – Nursing Facility Care (new in 2010)
  o 99324 - 99337 – Domiciliary, Rest Home or Custodial Care Services
  o 99341 - 99350 – Home Services (new in 2010)
  o G0101 - Cervical or vaginal screening, pelvic and clinical breast exam
  o G0108 - G0109 – Diabetes self-management training
What are the requirements for 2013?

- The reporting period is 12 months - (January 1, 2013 – December 31, 2013)
- All claims must be reported to CMS by February 24, 2014.
- One code is to be used to report the eRx measure
  - G8553 – At least one electronic prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.
- Electronically generated prescriptions NOT associated with the afore-mentioned 53 CPT Codes do not count towards the minimum eRx visits.
- There are no specific diagnoses for this measure.
- There are no age/gender requirements for this measure.
- Eligible professionals must have adopted a “qualified” e-prescribing system to participate in the program. There are two types of systems:
  - A system for e-prescribing only (stand-alone) or
  - An electronic health record (EHR system) with e-prescribing functionality

Regardless of the type of system used, to be considered “qualified,” the system must possess all of the following capabilities:

- Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit manager (PBMs), if available
- Selects medications, prints prescriptions, electronically transmit prescriptions, and conducts all alerts (defined below). This function must be enabled.
- Provide information related to lower cost, therapeutically appropriate alternatives (if any)
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available)

OR

- Is Certified EHR Technology as defined at 42 CHR 495.4 and 45 CFR 170.102. EHR technologies that meet these definitions are listed on the following ONC website, http://onc-chpl.force.com/ehrcert

AdvantEdge Healthcare Solutions
www.ahsrcm.com
information@ahsrcm.com
908-279-8120
Individual EP Reporting Option

Determination of whether an EP is a successful electronic prescriber will be made at the individual provider level, based on the National Provider Identification Number (NPI) number.

Some individuals may be associated with more than one practice or Tax Identification Number (TIN) and in these cases, the determination of whether an EP is a successful e-prescriber will continue to be made for each unique TIN/NPI combination. Incentive payments would be made to the applicable holder of the TIN.

For determining if an EP is a qualified EP under this program, CMS will use the National Plan and Provider Enumeration System (NPPES) data. It is an EP’s responsibility to ensure that his/her primary taxonomy code in NPPES is accurate.

Here are the requirements for an individual EP to qualify for the eRx Incentive Program.

- The EP must report the eRx measure for at least 25 unique electronic prescribing events. Each of the 25 prescribing events must be associated with one of the aforementioned 53 eligible CPT codes in the eRx program.

- The E-Prescribe measure may be reported via the following submission methods:
  - claim-based,
  - registry-based or
  - EHR-based options. (If an EP or group practice earns the eRx incentive under the Medicare EHR Incentive Program, the EP/group practice can not participate in this eRx program. An EP can not be paid twice)
  - All 25 e-prescribe events must be reported 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.
Group Practice Reporting Option (GPRO)

Group practices may want to participate in the eRx Incentive Program under the GPRO option. (This is not a requirement of a group practice. Group practices may participate in the program by allowing each of their EPs to submit separately with payment assigned to the group practice TIN. In this case, the EPs would follow the “individual EP” reporting method.)

Self-Nomination

All practices who want to participate in any of the GPRO alternatives must self-nominate and be selected by CMS to participate in this reporting method. A Group Practice may participate in a GPRO-PQRS reporting option and not participate in the GPRO-eRx Program option.

An individual EP who is affiliated with a GP successfully participating in the GPRO reporting option, would not be eligible to earn a separate individual eRx incentive payment based on the individual EP meeting the criteria for successful electronic reporting at the individual level.

Unlike prior years, in 2013, GPs are not required to participate in PQRS-GPRO or ACO-GPRO to participate in eRx-GPRO.

- In order for the group to participate in the GPRO-eRx reporting option, the GP must notify CMS of their desire to do so and the reporting method they plan to use for the calendar year. (claims-based, registry or EHR reporting)
- If group practices are participating in both PQRS-GPRO and eRx-GPRO, the above information may be submitted via the web. However, if the GP is part of an ACO or wishes to participate in the eRx-GPRO but not the PQRS-GPRO, the GP will be unable to self-nominate via the web but must instead submit an email self-nomination for eRx-GPRO.

See this CMS link for more information on the GPRO self-nomination process.

Once a group practice (TIN) is selected to participate in the eRx GPRO program; this is the only method of eRx reporting available to the group for all individual NPIs. At the end of the reporting period, regardless of the success or failure of a group practice participating in the GPRO eRx program; the program will prevent individual EPs from receiving eRx incentive payments for individual reporting under that TIN.

In order to be a successful GPRO e-prescriber:

- At least 10% of a group’s charges would need to be comprised of codes in the denominator (the 53 afore-mentioned CPT codes) of the electronic prescribing measures and the group would need to use an eRx that meets the requirements of the 2013 electronic prescribing measure.
• GPROS must submit:
  o For practices with 100 or more EPs - 2,500 or more unique denominator-eligible patient encounters
  o For practices with 25-99 EPs - 625 or more unique denominator-eligible patient encounters
  o For practices with 2-24 EPs – 75 or more unique denominator-eligible patient encounters

• The mechanisms for reporting via the GPRO reporting eRx option are:
  o Claims- based reporting
  o Qualified Registry-based Submission
  o Qualified Electronic Health Record (EHR) - based Submission

• CMS will not combine data submitted via multiple reporting mechanisms. All EPs within the group practice must submit via the same mechanism – claims-based, registry or EHR.

**eRx Reporting Mechanisms**

**CLAIMS-Based Reporting**

There is one reporting period for claims-based reporting for the 2013 incentive.

• 12 month reporting period – January 1, 2013 – December 31, 2013 (claims must be processed by CMS no later than February 24, 2014)

**REGISTRY-Based Reporting**

Only registries qualified to submit quality measure results and numerator and denominator data on PQRS quality measures would be qualified to submit the e-prescribe measure.

There is only one reporting period for registry-based reporting for the 2013 incentive program;

• 12 month reporting period: January 1, 2013 – December 31, 2013
• Registry reporting data for 2013 will be submitted to CMS via a Registry in the 1st quarter of 2014.

Registry vendors must submit a self-nomination statement by January 31, 2013. The list of approved qualified registries will be posted on the eRx Incentive Program section of the CMS Web site when the list of approved qualified registries is completed. A listing of 2012 qualified Registries can be found [here](#).
**EHR-Based Reporting**

The EHR-based reporting is an attempt by CMS to provide an opportunity for providers who participate in the PQRS Incentive Program via EHR as well as EPs who participate in the Medicare (or Medicaid) EHR Incentive Program, to use the same reporting mechanism for reporting the e-prescribe measure under the eRx program.

Only EHR systems qualified for reporting measures in the PQRS Incentive Program may be used for reporting the e-prescribe measure in the eRx program for the 2013 incentive.

There is only one reporting period for EHR-based reporting for the 2013 incentive program:

- 12 month reporting period: January 1, 2013 – December 31, 2013
- EHR data will be submitted to CMS during the 1st quarter of 2014

Only EHR vendors who have been vetted by CMS for the 2013 Physician Quality Reporting System/eRx Incentive Program and are on the posted list of EHR vendors are eligible to be considered “qualified” for purposes of reporting the 2013 eRx Incentive Program for purposes of the incentive payment.

A list of EHR Vendors for the 2013 eRx Incentive Program is available [here](#).

**2014 eRx Payment Adjustments**

EPs who do not successfully meet the following program criteria may receive 98.0% of the physician fee schedule amount (or 2% less) for covered professional services rendered from January 1, 2014 – December 31, 2014.

To avoid the 2014 eRx Payment Adjustment (penalty), an EP must have:

- Successfully reported the minimum number of eRx encounters for the 12-month reporting period of January 1, 2012 – December 31, 2012, or
- Successfully reported the minimum number of eRx encounters for the 6-month reporting period of January 1, 2013 – June 30, 2013; or
- Requested a 2013 eRx hardship exemption, or submit a lack of prescribing privileges G-code.

The 2014 eRx payment adjustment would **NOT** apply to the following:

- An EP who is not a physician, NP or PA as of June 30, 2013
- An EP who does not have at least 100 cases containing an encounter that falls within the denominator of the eRx measure for service dates of January 1, 2013 – June 30, 2013
- An EP’s Medicare charges to which the eRx measures applies (applicable denominator codes) are less than 10% of an EP’s total Medicare charges.
For determining if an EP is a qualified EP under this program, CMS will use the National Plan and Provider Enumeration System (NPPES) data. It is an EP’s responsibility to ensure that his/her primary taxonomy code in NPPES is accurate.

Since there are concerns with the reliability of information contained in the NPPES, EPs who do **NOT** have prescribing privileges must report a specific G-code on at least one claim with dates of service January 1, 2013 – June 30, 2013 to inform CMS that they should not receive a payment adjustment.

- **This code is G8644 – EP does not have prescribing privileges.**

**Individual EP Reporting Options to Avoid Penalties:**

The reporting periods for payment adjustments in the year **2014:**

- **January 1, 2012 – December 30, 2012**  - reporting on the numerator code at least 25 times for encounters associated with at least 1 denominator code via claims, registry and EHR submission, *via claims, registry and EHR submission*, and
- **January 1, 2013 – June 30, 2013** – reporting the electronic prescribing measure’s numerator code at least 10 times, *via claims only.*

**GPRO Reporting Options to Avoid Penalties:**

The reporting period for payment adjustments in the year **2014:**

- **January 1, 2012 – December 30, 2012**  
  - **GPs with 25 – 99 EPs**  - Must report the electronic prescribing measure’s numerator code at least 625 times for encounters associated for at least 1 of the denominator codes, *via claims, registry and EHR submission*  
  - **GPs for 100+ EPs**  - Must the electronic prescribing measure’s numerator code at least 2,500 times for encounters associated for at least 1 of the denominator, *via claims, registry and EHR submission*
- **January 1, 2013 – June 30, 2013**  
  - **GPs with 25 – 99 EPs**  - Must report the electronic prescribing measure’s numerator code at least 625 times, *via claims only*  
  - **GPs for 100+ EPs**  - Must the electronic prescribing measure’s numerator code at least 2,500 times, *via claims only*

*During the 6-month reporting period of January 1, 2013 – June 30, 2013, an EP would be able to report the G8553 code regardless of whether the G8553 code was performed with one of the 53 denominator codes, as CMS recognizes that EPs may generate prescriptions during*
encounters that are not necessarily included in those codes. However, the G8553 code must be submitted with another payable Medicare B fee-for-service code. The G8553 code may not be submitted alone. All claims submitted during the 6-month reporting period must be processed into Medicare’s National Claims History by July 26, 2013.

2013 & 2014 Significant Hardship Exemptions

EPs or GPs may on a case-by-case basis, be exempt from the application of the payment adjustment, if the Secretary of HHS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

The 4 Significant Hardship Exemptions from last year are still available for the 2014 to avoid the 2014 payment adjustment as well as two new hardships which are tied to the EHR Incentive Program and are available for both the 2013 and 2014 payment adjustments.

Two New Hardship Exemptions

1. EPs who achieve meaningful use during the respective six or 12 month payment adjustment reporting periods.

To avoid the 2013 payment adjustment - EPs must have achieved meaningful use of CEHRT under the EHR Incentive Program for:

- A continuous 90 day EHR reporting period that falls within the 12 month calendar year of January 1, 2011 – December 31, 2011, or
- A 6 month (January 1, 2012 – June 30 2012) penalty reporting period, or
- For an EHR reporting period that is the full calendar year 2012 (To qualify for this exemption you must meet the criteria by January 31, 2013.

To avoid the 2014 payment adjustment - EPs must have achieved meaningful use of CEHRT (Certified EHR Technology) under the EHR Incentive Program for:

- A continuous 90 day EHR reporting period that falls within the 12-month year of January 1, 2012 – December 31, 2012, or
- A continuous 90 day EHR reporting period that falls within the 6-month penalty period of January 1, 2013 – June 30, 2013, or
- An EHR reporting period that is the full calendar year 2012
2. EPs who have registered to participate in the EHR Incentive Program and adopted CEHRT prior to the application of the respective payment adjustment.

To Avoid the **2013 Payment Adjustment** - An EP must demonstrate intent to participate in the EHR Incentive Program by registering for the program between January 2, 2012 and December 31, 2012 and adopt CEHRT. To qualify for this exemption EPs must meet the criteria by January 31, 2013.

To Avoid the **2014 Payment Adjustment** - An EP must demonstrate intent to participate in the EHR Incentive Program by registering for the program between January 1, 2013 and June 30, 2013 and adopt CEHRT. Participants must enter the EHR Certification Number for the EHR product in the registration and attestation system to be eligible for this exemption category.

EPs do not need to apply for these 2 hardship exemptions through the Quality Reporting Communication Support web page. CMS will use the information collected from the EHR Incentive Program’s registration and attestation page to automatically exempt eligible EPs from both the 2013 and 2014 penalties under these two categories. **However, EPs must register and attest to the EHR Meaningful Use Program by January 31, 2013.**

**Standard Significant Hardship Exemptions**

Significant hardship exemptions for the 2014 Payment Adjustment Year are:

- G8642 - practices in a rural area with limited high speed internet access; or
- G8643 - practices in an area with limited available pharmacies for electronic prescribing.
- Has the inability to electronically prescribe due to local, state, or federal law or regulation
- Is an EP who prescribes fewer than 100 prescriptions during a 6-month payment adjustment reporting period.

The reporting period for submitting significant hardship exemptions is January 1, 2013 – June 30, 2013. Information to be submitted:

- Name of Practice and other identifying information such as TIN, NPI, mailing addresses, email addresses of all affected EPs
- The hardship exemption categories that apply
- A justification statement describing how compliance with the e-prescribe requirement would be a significant hardship and that the justification statement be specific as to the exemption category, including a statement as to how the exemption applies. (i.e., if the EP is requesting a hardship exemption due to Federal, state or local law or regulation, he/she must cite the applicable law and how the law restricts the EP’s ability to e-prescribe.
- An attestation of the accuracy of the information provided.
EPs may also have to submit additional documentation if CMS determines that the request was accompanied by insufficient information to justify the request or make the determination whether a significant hardship exists.

EPs/GPs will submit the hardship exemption requests using CMS’ web-based tool or interface called the Communication Support Page, found at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

Two of the hardship exemptions may be submitted on claims in addition to using the web-based tool or interface:

- G8642 - practices in a rural area with limited high speed internet access; or
- G8643 - practices in an area with limited available pharmacies for electronic prescribing.

The deadline to submit requests for significant hardship exemptions is **June 30, 2013**.

Information on the 2014 payment adjustment as well as information on how to submit a hardship exemption can be found in **ADDENDUM A - CMS Links to Documents**, under **Payment Adjustments and Hardship Exemptions**.

**Informal Review/Appeals Process**

In the 2013 Medicare Physician Fee Schedule, CMS finalized an informal review or appeals process which will allow EPs to contest 2012 and 2013 e-prescribing incentive payments, as well as 2013 and 2014 penalty decisions.

- To contest the 2012/2013 incentive payments, EPs must submit, via email, a request for review within 90 days of receipt of the respective feedback report.
- To contest the 2013/2014 penalty decisions, EPs must submit a request for review by February 28, 2013 and February 28, 2014, respectively.

CMS will provide a written response to all reviews and their decision will be final. More information will be published on this program by CMS in the near future.
## ADDENDUM A - CMS LINKS

### E-PRESCRIBE MEASURE INFORMATION

Website Home Page:  
eRx Incentive Program  

**DOWNLOADS**

**2013 Measure Specifications**

### GROUP PRACTICE REPORTING OPTION (GPRO)

Website Home Page:  
GPRO Reporting Option  

**DOWNLOADS**

**GPRO Measure Specifications**

**2013 GPRO Requirements**

### EHR & REGISTRY-BASED REPORTING

Website Home Page:  
Electronic Health Record Reporting Home Page  

**DOWNLOADS**

**2013 EHR eRx Documents for Eligible Professionals [ZIP 2MB]**

### PAYMENT ADJUSTMENTS AND SIGNIFICANT HARDSHIP EXEMPTIONS

Website Home Page:  
Payment Adjustment Information  

**DOWNLOADS:**

**2013 eRx Payment Adjustment Feedback Report User Guide**

Communication Support Page
ADDENDUM B - Eligible Professionals to report the 2012 eRx Measure

1. 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. Practitioners
   - Physician Assistant
   - Nurse Practitioner
   - Clinical Nurse Specialist
   - Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
   - Certified Nurse Midwife
   - Clinical Social Worker
   - Clinical Psychologist
   - Registered Dietician
   - Nutrition Professional
   - Audiologists (as of 1/1/2009)

3. Therapists
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist (as of 7/1/2009)

Eligible But Not Able to Participate

The following professionals are eligible to participate but are not able to participate for one or more reasons:

1. Providers paid under the Medicare PFS billing Medicare fiscal intermediaries/MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:
   - 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.

Providers not defined as eligible professionals in the Tax Relief Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the PFS are not included in PQRS (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRS since DME is not paid under the PFS.