

The eRx Incentive Program – A Resource Guide

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 the Division B of the Tax Relief and Health Care act of 2006 – Medicare Improvements and Extension Act of 2006 (MIEA-TRHCA).

The incentive program actually began on January 1, 2009 and each year the program is reviewed and changes implemented by CMS through the annual rulemaking process, usually as part of the Medicare Physician Fee Schedule (MPFS) and published in the Federal Register. The 2012 MPFS included updates for the 2011, 2012 and 2013 incentive program years. Information for years 2012 and 2013 are included in this resource guide.

AHS compiled this eRx ***Incentive Program Resource Guide*** to assist our clients and staff in understanding the eRx program by locating all of its important information in one place. We have summarized the program and also given you the CMS links for further documentation, 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 the CMS manuals 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

2012 eRx Incentive Program - The Basics

The 2012 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 2012 & 2013 eRx Program:

- The incentive payment for the 2012 reporting period is 1% 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.
 - The incentive payment for the 2013 reporting period is 0.5%
 - There are no incentives or payment adjustments currently scheduled past 2014

- 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 1.5% of his/her Medicare allowed charges for 2012. (1% for PQRS and 0.5% for eRx)
- **Qualified providers who do not report via electronic prescribing in 2012, will receive a 2% reduction in their Medicare reimbursements for 2014.**
- EPs may participate in the eRx Incentive Program:
 - As an individual EP; or
 - As part of a Group Practice Reporting Option (GPRO)
- For information on EPs who do not have to report the e-prescribe measure and will not be penalized for doing so, please see the Payment Adjustment section of this guide.

Who May Participate in the 2012 eRx Incentive Program?

- The EP must be a physician, Nurse Practitioner or a Physician Assistant as of June 30, 2012. A complete listing of eligible providers is available in ADDENDUM B.
- 10% of an EP's Medicare Part B charges must be comprised of the 56 codes in the denominator of the measure for the EP to be incentive eligible. Eligible CPT codes are:
 - 90801 – 90809 & 90862 – Psychiatric and psychotherapy (90862 new in 2010)
 - 92002 - 92014 – General Ophthalmological
 - 96150 – 96152 – Health & Behavior assessment
 - 99201 – 99215 – E & M Visit Codes
 - 99304 – 99316 – Nursing Facility Care (new in 2010)
 - 99324 – 99337 – Domiciliary, Rest Home or Custodial Care Services
 - 99341 – 99350 – Home Services (new in 2010)
 - G0101 – Cervical or vaginal screening, pelvic and clinical breast exam
 - G0108 – G0109 – Diabetes self-management training
- An EP must have at least 100 cases (claims for patient services) containing an encounter that falls within the denominator (the 56 CPT codes) of the electronic e-prescribe measure for service dates during the 6-month reporting period of:
 - January 1, 2012 – June 30, 2012 for payment adjustment year 2013
 - January 1, 2013 – June 30, 2013 for payment adjustment year 2014

What are the requirements for 2012?

- The reporting period is 12 months - (January 1, 2012 – December 31, 2012)
- All claims must be reported to CMS by February 22, 2013.
- 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 56 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.

Individual EP Reporting

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 56 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.

Group practices may only report eRx e-prescribing via the GPRO method if they submitted their intention to be a GPRO eRx prescriber during their GPRO ***PQRS*** self-nomination process. Participation is limited to group practices selected to participate in the PQRS GPRO reporting method and are reporting the eRx measure as a CMS selected eRx GPRO. (***See our PQRS Resource Guide for more information on the GPRO self-nomination process for the PQRS and the eRx Incentive Programs.***)

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 participate in the GPRO eRx program; the program will prevent individual EPs from receiving eRx incentive payments for individual reporting under that TIN.

GPROs must also indicate which reporting mechanism the group practice intends to use to report the e-prescribe measure; claims-based, registry or EHR-based reporting during the self-nomination process.

In order to be a successful GPRO e-prescriber:

- 10% of a **group's** charges would need to be comprised of codes in the denominator (the 56 afore-mentioned CPT codes) of the electronic prescribing measures and the group would need to use an eRx that meets the requirements of the 2011 electronic prescribing measure.
- GPROs must submit:
 - For practices with 100 or more EPs - 2,500 or more unique denominator-eligible patient encounters
 - For practices with 25-99 EPs - 625 or more unique denominator-eligible patient encounters
- The mechanisms for reporting via the GPRO reporting eRx option are:
 - Claims- based reporting
 - Qualified Registry-based Submission
 - Qualified Electronic Health Record (EHR) - based Submission
- An individual EP who is affiliated with a GP participating in the GPRO reporting option that successfully meets the requirements of being a successful e-prescriber under a GP would not be eligible to earn a separate eRx incentive payment on the basis of the individual EP meeting the criteria for successful electronic reporting at the individual level.
- A Group Practice may participate in a GPRO PQRS reporting option and not participate in the GPRO eRx Program option. However, if a group practice wants to participate in the GPRO eRx reporting option, that group practice must also participate in the GPRO PQRS reporting option
 - In order for the group to participate in the GROP eRx reporting option, the **GP must indicate its desire to do so at the same time** that the GP self-nominates to participate in the 2011 PQRS GROP reporting option.
- CMS will not combine data on the eRx 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 2012 incentive .

- 12 month reporting period – January 1, 2012 – December 31, 2012 (claims must be processed by CMS no later than February 22, 2013)

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 2012 incentive program;

- 12 month reporting period: January 1, 2012 – December 31, 2012

The list of approved qualified registries be posted on the eRx Incentive Program section of the CMS Web site when the list of approved qualified registries for the PQRS Incentive program is posted.

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 2012 and 2013 incentives.

The self-nomination process and requirements for direct EHR -based reporting products and EHR data submission vendors for the PQRS reporting system would apply to the eRx program.

Direct EHR based reporting vendors and EHR data submission vendors must indicate their desire to have one or more of their EHR products approved for use in the eRx program for the 2012 and 2013 incentive years at the same time they self-nominate for the respective 2012 and 2013 PQRS program.

There is only one reporting period for EHR-based reporting for the 2012 incentive program;

- 12 month reporting period: January 1, 2012 – December 31, 2012

The list of approved EHR technology, their approved vendors for the eRx program would be posted on the eRx Incentive Program section of the CMS Web site when the list of approved HER technology for the PQRS program is posted.

eRx Payment Adjustments

If an EP is not a successful e-prescriber for the reporting period, the Physician Fee Schedule (PFS) amount for covered professional services furnished by the EP shall be less than the PFS that would otherwise be applied by:

- 1.5% for 2013
- 2.0% for 2014

The 2013 eRx payment adjustment would **NOT** apply to the following:

- An EP who is not a physician, NP or PA as of June 30, 2012
- An EP who does not have at least 100 cases (claims for patient services) containing an encounter that falls within the denominator of the eRx measure for service dates of January 1, 2012 – June 30, 2012
- An EPs 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, 2012 – June 30, 2012 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 period for payment adjustments in the year **2013**:

- **January 1, 2011 – December 30, 2011** - reporting on the numerator code at least 25 times for encounters associated with at least 1 denominator code **via claims, registry and EHR submission**, and
- **January 1, 2012 – June 30, 2012** – reporting the electronic prescribing measure’s numerator code at least 10 times, **via claims only**. (claims must be processed by CMS no later than July 27, 2012)

IMPORTANT: This means that ***if an EP did not submit 25 eRx encounters in calendar year 2011, he/she may still submit 10 encounters for service dates January 1, 2012 – June 30, 2012 to not receive a 2013 penalty.***

During This 6 month period of January 1, 2012 – June 30, 2012, an EP would be able to report the G8553 code regardless of whether the code for such service appears in the denominator because CMS recognizes that EPs may generate prescriptions during encounters that are not necessarily included in the measure’s denominator.

The reporting period 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 options are the same as the individual EP reporting options except for the number of e-prescribe measures that must be submitted to CMS.

The reporting period for payment adjustments in the year **2013**:

- **January 1, 2011 – December 30, 2011**
 - **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, 2012 – June 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 only***
 - **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 only***

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 for encounters associated for at least 1 of the denominator codes, ***via claims only***
 - **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 only***

2012 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.

Significant hardship exemptions for payment adjustment years 2013 and 2014 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.

Process for Submitting Significant Hardship Exemptions

The reporting periods for submitting significant hardship exemptions are:

- For the 2013 payment adjustments – January 1, 2012 – June 30, 2012
- For the 2014 payment adjustments – 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 would 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

More information is available on this tool is available on the CMS website at: <http://www.com.gov/ERXincentive>.

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:

- For the 2013 adjustment payment - June 30, 2012.
- For the 2014 adjustment payment – June 30, 2013

Information on the 2012, 2013, and 2014 payment adjustments as well as information on how to submit a hardship exemption can be found on ADDENDUM A - **CMS Links to Documents**, under ***Payment Adjustments and Hardship Exemptions***.

ADDENDUM A - CMS LINKS

E-PRESCRIBE MEASURE INFORMATION

Website Home Page:

https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp#TopOfPage

DOWNLOADS

[2012 eRx Measure Specifications, Release Notes, and Claims-Based Reporting Principles \[ZIP 475KB\]](#)

[2012 eRx CMS-1500 Claims Example \[PDF 354KB\]](#)

GROUP PRACTICE REPORTING OPTION (GPRO)

Website Home Page:

https://www.cms.gov/ERxIncentive/07_Group_Practice_Reporting_Option.asp#TopOfPage

DOWNLOADS

[2012 GPRO eRx Measure Specifications, Release Notes and Claims Based Reporting Principles \[ZIP 482KB\]](#)

[Physician Quality Reporting System GPRO](#)

EHR & REGISTRY-BASED REPORTING

Website Home Page:

https://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage

DOWNLOADS

[2012 EHR eRx Documents for Eligible Professionals \[ZIP 2MB\]](#)

[2011 Qualified Registries \[PDF 283KB\]](#)

PAYMENT ADJUSTMENTS AND SIGNIFICANT HARDSHIP EXEMPTIONS

WebSite Home Page;

https://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp

DOWNLOADS:

[Quick-Reference Guide for Understanding the 2012 eRx Payment Adjustment \[PDF 70KB\]](#)

[Tips for Using the Quality Reporting Communication Support Page \[PDF 70KB\]](#)

[2011 eRx Incentive Program Update for 2012 Payment Adjustment \[PDF 21KB\]](#)

[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.

