Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program

During the Group Practice Reporting Option (GPRO) vetting process, please submit your intention to report the Electronic Prescribing measure. Hardship G-Codes are available to submit, if applicable. Please refer to Electronic Prescribing Measure Specification for further information on the Hardship G-Codes.

For details regarding the payment adjustment related to electronic prescribing, please refer to the documents in the Downloads section of the Educational Resources page on the Electronic Prescribing Incentive Program website.

For successful reporting under the 2011 eRx Incentive Program, a single quality-data code (eRx G-code) should be reported, according to the following coding and reporting principles:

- Report the following eRx numerator G-code, when applicable:
    - G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

- The eRx G-code, which supplies the numerator, must be reported:
    - on the claim(s) with the denominator billing code(s) that represent the eligible encounter
    - for the same beneficiary
    - for the same date of service (DOS)
    - by the same eligible professional (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator

- The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed:
    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the Carrier/MAC, the eRx G-code line is denied and tracked.
    - eRx line items will be denied for payment, but are passed through the claims processing system to the National Claims History database (NCH), used for eRx claims analysis. Eligible professionals will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 remark code does **NOT** indicate whether the eRx G-code is accurate for that claim or for the measure the eligible professional is attempting to report. N365 only indicates that the eRx G-code passed into NCH.

- When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.

Submission through Carriers/MACs
eRx G-codes shall be submitted to Carriers/MACs either through:
Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or via paper-based submission, using the CMS-1500 claim form.

Electronic Submission:
The eRx G-code should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.

- It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.
- Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.
- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data element **NM109 (NM108=XX)**.

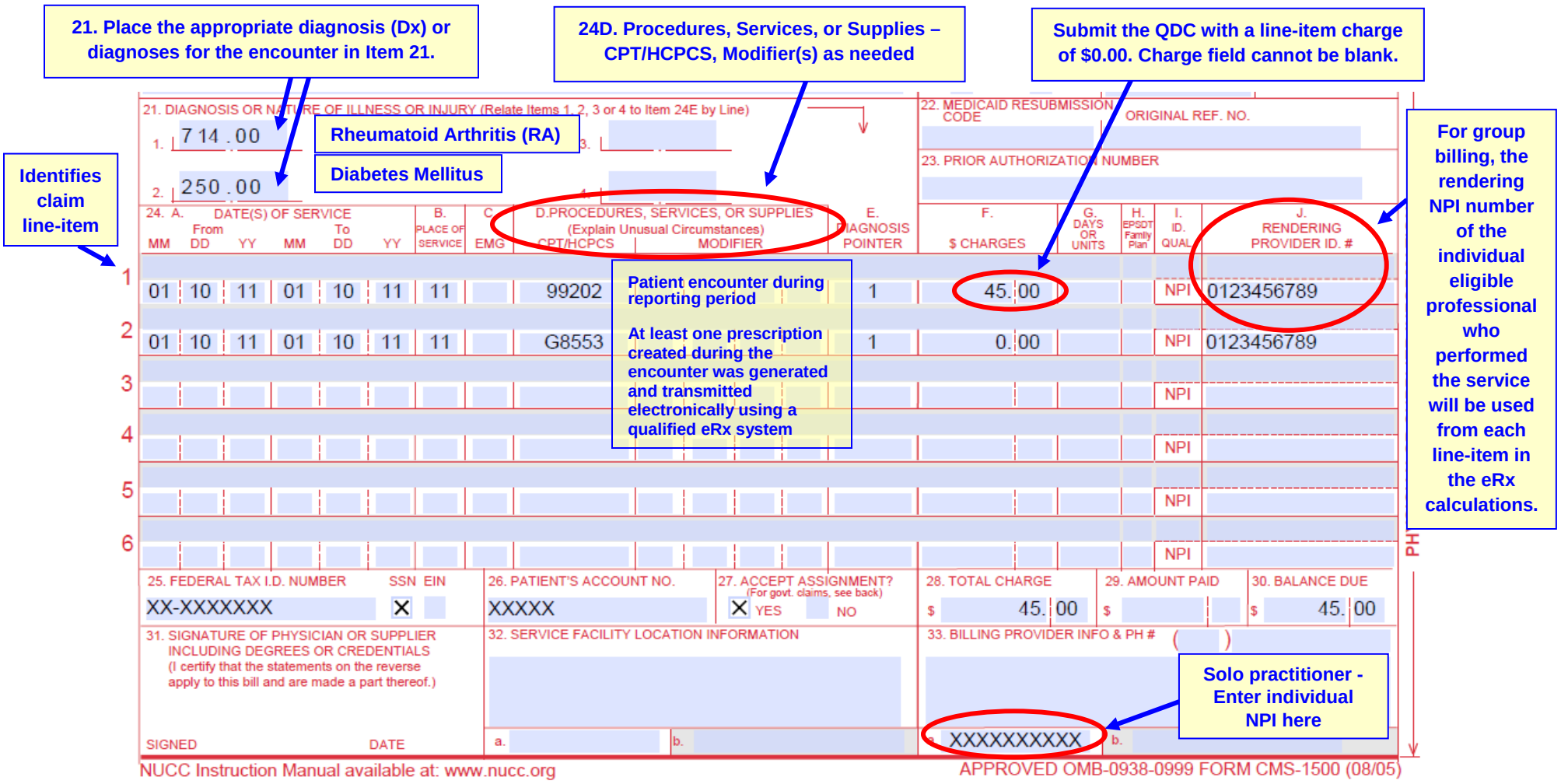
Paper-based Submission:
Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05) as described in the claim sample below. Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in Field 21.

- For group billing, the NPI of the rendering/performing provider is entered in **Field 24J** and the TIN of the employer is entered in **Field 25**.

Timeliness of Quality Data Submission
Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (NCH file) by February 24, 2012 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Appendix A: CMS-1500 Claim Electronic Prescribing Example

A detailed sample of an individual NPI reporting the Electronic Prescribing (eRx) measure on a CMS-1500 claim is shown below.



The patient was seen for an **office visit (99202)**. The provider is reporting the **eRx measure:**

- eRx **QDC G8553** (indicating all prescriptions generated via qualified eRx system).
- **Note:** eRx includes encounter (CPT Category I) codes only. All diagnoses listed in **Item 21** from the encounter will be used for PQRI analysis.
- **NPI placement: Item 24J** must contain the NPI of the individual provider who rendered the service when a group is billing.

For more information on the CMS 1500 claim form, see http://cms.gov/manuals/downloads/clm104c26.pdf.