CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 459	**Date: MARCH 20, 2009**
	Change Request 6394

SUBJECT: Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) and the 2009 Electronic Prescribing (E-Prescribing) Incentive Program

I. SUMMARY OF CHANGES: The purpose of this CR is to provide high-level overviews of the 2009 PQRI implementation and the new 2009 E-Prescribing Incentive Program implementation, as directed by the statute.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***January 1, 2009
IMPLEMENTATION DATE: June 22, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 459	Date: March 20, 2009	Change Request: 6394

SUBJECT: Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) and the 2009 Electronic Prescribing (E-Prescribing) Incentive Program

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I. GENERAL INFORMATION

A. Background:

The 2006 Tax Relief and Health Care Act (P.L. 109-432) (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. CMS named this program the Physician Quality Reporting Initiative (PQRI).

For the 2009 PQRI, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA) required the Secretary to select measures for 2009 through rulemaking and to establish alternative reporting criteria and alternative reporting periods for reporting measures groups and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. The 2009 PQRI requirements are outlined in the 2009 Medicare Physician Fee Schedule (MPFS) final rule with a comment period that was published in the **Federal Register** on November 19, 2008 and are summarized below. (See: *http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf*)

Section 132 of the MIPPA also authorizes a new and separate incentive program for eligible professionals who are successful electronic prescribers (e-prescribers) as defined by MIPPA. This new incentive is separate from and is in addition to the PQRI. The 2009 program requirements for the E-Prescribing Incentive Program are also outlined in the 2009 MPFS final rule with comment period and summarized below.

The purpose of this document is to give high-level overviews of the 2009 PQRI implementation and the new 2009 E-Prescribing Incentive Program implementation, as directed by the statute.

The 2009 PQRI overview section highlights changes from the 2008 PQRI with respect to: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment for reporting, (5) individual quality measures, (6) measures groups, (7) determination of satisfactory reporting, (8) validation, (9) appeals, and (10) confidential feedback reports. Educational materials and supportive tools for the 2009 PQRI will be posted as they become available on the CMS PQRI website at *http://www.cms.hhs.gov/PQRI.*

The 2009 E-Prescribing Incentive Program overview section addresses: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment for reporting, (5) determination of a successful e-prescriber, and (6) confidential feedback reports. Educational materials and supportive tools for the 2009 E-Prescribing Incentive Program will be posted as they become available on the CMS E-Prescribing Incentive Program website at *http://www.cms.hhs.gov/ERXIncentive*.

B. 2009 PQRI Overview

1. Eligible Professionals

Beginning with the 2009 PQRI, the definition of "eligible professional" has been expanded to include qualified audiologists, as required by the MIPPA. Therefore, for the 2009 PQRI, the following professionals are eligible to participate in PQRI:

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. 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

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons.

<u>Professionals eligible to participate but not able to participate include:</u>

1. Certain Professionals paid under or based upon the MPFS billing Medicare Carriers or Medicare Administrative Contractors (MACs) who do not bill directly. For example, Qualified Speech-Language Therapists do not currently bill Medicare directly. It is anticipated that Qualified Speech-Language Therapists will begin billing Medicare directly on July 1, 2009 at which point they would be able to participate.

2. Professionals paid under the MPFS whose services are billed on claims submitted to Medicare fiscal intermediaries (FIs) or 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 FI/MAC 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.

Professionals not eligible to participate in the PQRI and not able to qualify to earn an incentive payment include:

1. Those that are 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.

2. Services payable under fee schedules or methodologies other than the MPFS are not included in PQRI (for example, services provided by federally qualified health centers, clinical laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

3. Suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not paid under the MPFS.

2. Form and Manner of Reporting

TRHCA section 101 allows CMS to specify the form and manner of reporting. Beginning with the 2008 PQRI, the MMSEA required the Secretary to establish alternative reporting criteria and alternative reporting periods for registry-based reporting. For 2009, eligible professionals can continue to choose whether to report through claims-based submission or through a qualified PQRI registry. In addition, eligible professionals can continue to choose to report on individual quality measures or on measures groups.

- Claims-based submission:
  There is no need to enroll or register to begin claims-based reporting for the 2009 PQRI. Participating eligible professionals whose Medicare patients fit the specifications of the 2009 PQRI quality measures and/or measures groups will simply report the corresponding appropriate CPT Category II codes or G-codes (where CPT Category II codes are not yet available) on their claims. CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P.

  The applicable CPT Category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. The analysis algorithms that determine satisfactory reporting match the quality-data codes to the diagnosis, service, and procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward satisfactory reporting or for calculation of a potential incentive payment. Additional guidance about how to implement 2009 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by eligible professionals for the 2009 PQRI is available in the *2009 PQRI Implementation Guide*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*

- Registry-based reporting:
  Eligible professionals should submit information to a qualified PQRI clinical data registry and authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

For 2009, CMS will conduct another self-nomination process for registries so additional registries can potentially be approved for submitting quality measures data for the 2009 PQRI. Registries qualified to submit data on behalf of their eligible professionals in 2008 are not required to self-nominate again for 2009 unless they are unsuccessful at submitting 2008 data by March 31, 2009. The list of qualified registries for the 2009 PQRI will be available on the CMS PQRI website at *http://www.cms.hhs.gov/PQRI* in the summer of 2009.

3. Reporting Periods

There are no changes to the PQRI reporting period or the alternative reporting periods for measures group reporting or for registry-based reporting for 2009. In other words, the 2009 PQRI reporting period continues to be the entire calendar year.

There also continues to be 2 alternative reporting periods for measures group reporting and for registry-based reporting (i.e., the entire calendar year and a six-month reporting period beginning July 1, 2009).

4. Payment for Reporting

Participating eligible professionals who satisfactorily report as prescribed by the 2009 MPFS final rule with comment period (and as summarized below in the Determination of Satisfactory Reporting section) may earn a 2.0% incentive payment. The potential 2.0% incentive payment will be based on estimated allowed charges for covered professional services: (1) furnished during the applicable reporting period, (2) received into the CMS National Claims History (NCH) file by February 28, 2010, and (3) paid under or based upon the MPFS. Because claims processing times may vary by time of the year and Medicare Carrier/ MAC, participating eligible professionals should submit claims from the end of 2009 promptly, so that those claims will reach the NCH file by February 28, 2010. PQRI incentive payments will be paid as a lump sum in mid-2010. There is no beneficiary co-payment or notice to the beneficiary regarding the PQRI incentive payments.

The PQRI incentive payment will apply to allowed charges for all covered professional services under the MPFS not just those charges associated with reported quality measures. The term “allowed charges” refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the MPFS amounts for assigned and non-assigned claims will not apply to the incentive payment. The statute defines PQRI covered services as those paid under or based upon the MPFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the MPFS do not apply to the PQRI incentive payment.

For 2009, the analysis of satisfactory reporting will continue to be performed at the individual eligible professional level using individual-level National Provider Identifier (NPI) data. CMS, however, will continue to use the Taxpayer Identification Number (TIN) as the billing unit, so any PQRI incentive payments earned will be paid to the TIN holder of record. PQRI incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will continue to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the PQRI incentive payment under more than one TIN will receive a separate PQRI incentive payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, section 1848(m)(1)(A)(ii) of the Act specifies that any PQRI incentive payment earned will be paid to the employers or facilities.

5. Individual Quality Measures

The 2009 PQRI includes a total of 153 quality measures. This total includes 52 new measures. In addition, whereas all of the 2008 PQRI quality measures were reportable either through claims-based submission or registry-based reporting, 18 of the 153 PQRI quality measures for 2009 are reportable **only** through registries. A complete list of the 2009 PQRI individual quality measures can be found in the *2009 PQRI Quality Measures List*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

Detailed measure specifications for the 2008 PQRI quality measures selected for the 2009 PQRI may have been updated or modified during the National Quality Forum endorsement process or for other reasons prior to 2009. The 2009 PQRI quality measure specifications for any given quality measure may, therefore, be different from specifications for the same quality measure used for 2008. Specifications for all 2009 PQRI quality measures must be obtained from the *2009 PQRI Specifications Manual*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

6. Measures Groups

There are 7 measures groups for the 2009 PQRI.

The ESRD measures group is not included in the 2009 PQRI. The following 3 PQRI measures groups from 2008 are being retained for 2009 PQRI:
(1) Diabetes Mellitus
(2) CKD
(3) Preventive Care.

The measures that form the Diabetes Mellitus and CKD measures groups for the 2009 PQRI are different from the measures that were included in these measures groups for 2008.

There are 4 new measures groups for the 2009 PQRI: CABG, Rheumatoid Arthritis, Perioperative Care, and Back Pain.

The measures in the Back Pain measures group are reportable **only** as a measures group, not as individual measures. The CABG measures group is reportable **only** via registry submission, not claims-based submission.

Measures groups specifications are different from the specifications for individually reported measures that form the group. Therefore, the specifications, including the list of measures selected for inclusion in each of the 2009 PQRI measures groups, and reporting instructions for the 2009 PQRI measures groups are provided separately in the *2009 PQRI Measures Groups Specifications Manual* available as a downloadable document in the Measures/Codes section of the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*. New for 2009, if ***all*** quality actions for the applicable measures in a measures group have been performed for the patient, **one G-code** may be reported in lieu of the individual quality-data codes for each of the measures within the group.

7. Determination of Satisfactory Reporting

In order to qualify to earn an incentive payment, eligible professionals must meet the criteria for satisfactorily reporting data on PQRI quality measures. The criteria that are applicable depend on the reporting period an eligible professional chooses to report, the manner in which an eligible professional reports (whether through claims or a qualified PQRI registry), and whether an eligible professional chooses to report on individual quality measures or on measures groups. For the 2009 PQRI, there are a total of 9 reporting options, or ways in which an eligible professional can attempt to satisfactorily report. Although there are multiple reporting options for satisfactory reporting, an eligible professional only needs to satisfactorily report under one option to qualify for the 2.0% incentive payment for the applicable reporting period. An eligible professional who qualifies for more than one reporting period will receive the incentive payment for the longest reporting period for which the professional qualifies. Only one incentive payment may be obtained regardless of how many reporting options the eligible professional chooses.

While the number of reporting options remains the same as in 2008, there are some differences between the 2008 PQRI reporting options and the 2009 PQRI reporting options. The 2009 PQRI reporting options, including any changes, are summarized below.

Table 1: Criteria for Satisfactory Reporting of Individual Quality Measures through Claims (no changes from 2008 PQRI)

Reporting Criteria	Reporting Period
At least 3 PQRI measures, or 1-2 measures if less than 3 apply to the eligible professional, for 80 % of applicable Medicare Part B fee-for-service (FFS) patients of each eligible professional.	January 1, 2009 – December 31, 2009

Table 2: Criteria for Satisfactory Reporting of Individual Quality Measures through Registries (no changes from 2008 PQRI)

Reporting Criteria	Reporting Period
At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009 – December 31, 2009
At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	July 1, 2009 – December 31, 2009

Criteria for Claims-based Submission of Measures Groups

For the 2009 PQRI, there are 3 reporting options for claims-based submission of measures groups. Whereas for the 2008 PQRI only the 6-month reporting period was available for claims-based submission of measures groups, both the 12-month and the 6-month reporting periods are available for claims-based submission of measures groups for the 2009 PQRI. In addition, we have added a minimum sample size requirement for eligible professionals reporting on at least 80% of applicable Medicare Part B FFS patients. Eligible professionals reporting on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period must have at least 30 applicable patients. Eligible professionals reporting on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period must have at least 15 applicable patients. We have, however, eliminated the option under the 2008 PQRI of reporting on at least one measures group on 15 consecutive Medicare Part B FFS patients for the 6-month reporting period. Instead, for the 2009 PQRI, eligible professionals may report on at least 30 consecutive Medicare Part B FFS patients for the 12-month reporting period. The criteria for claims-based submission of measures groups are summarized in **Table 3** below.

Table 3: Criteria for Satisfactory Reporting of Measures Groups through Claims

Reporting Criteria	Reporting Period
One measures group for 30 consecutive Medicare Part B FFS patients of each eligible professional.	January 1, 2009 – December 31, 2009
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009 – December 31, 2009
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009 – December 31, 2009

Criteria for Registry-Based Reporting of Measures Groups

With the exception of permitting consecutive patient samples to include some non-Medicare patients under the registry-based reporting of measures groups, the criteria for registry-based reporting of measures groups are identical to the criteria for claims-based submission of measures groups for the 2009 PQRI. In addition, the only difference between the 2008 criteria for registry-based reporting of measures groups and the 2009 criteria is the addition of a minimum sample size requirement for eligible professionals reporting on at least 80% of applicable Medicare Part B FFS patients. Identical to the 2009 criteria for claims-based submission of measures groups, eligible professionals reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period must have at least 30 applicable patients. Eligible professionals reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period must have at least 15 applicable patients. The criteria for registry-based reporting of measures groups are summarized in **Table 4** below.

Table 4: Criteria for Satisfactory Reporting of Measures Groups through Registries

Reporting Criteria	Reporting Period
One measures group for 30 consecutive patients of each eligible professional. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2009 – December 31, 2009
One measures group for 80 % of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009 – December 31, 2009
One measures group for 80 % of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009 – December 31, 2009

As stated in the Payment for Reporting section, the analysis of whether an eligible professional has satisfactorily reported will continue to be performed at the individual eligible professional level using the individual-level NPI. The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2009 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures and/or measures groups that are applicable to their practices. If an eligible professional submits data for a quality measure or a measures group, then that measure or measures group is presumed to be applicable for the purposes of determining satisfactory reporting. For eligible professionals choosing to report on individual quality measures, CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to increase the likelihood that they will reach the 80% satisfactorily reporting requirement for the requisite number of measures.

As detailed information, education, and tools to support satisfactory claims-based reporting of individual quality measures and/or measures groups become available, they will be posted on the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

8. Validation

Section 1848(m)(5)(D)(ii) of the Social Security Act (the Act) permits CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional

have been reported. Under the claims-based reporting method of individual measure(s), the determination of satisfactory reporting, as defined by statute, will itself serve as a general validation because the analysis will assess whether quality-data codes are appropriately submitted by an eligible professional in a sufficient proportion of the instances when a reporting opportunity exists. In addition, for those eligible professionals who satisfactorily submit quality-data codes for fewer than three (3) PQRI measures, a two-step measure-applicability validation (MAV) process will determine whether they should have submitted quality-data codes for additional measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the incentive payment. More information on the MAV process for the 2009 PQRI is available in the Analysis and Payment section of the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

9. Appeals

For the 2009 PQRI, the statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, or (3) the incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

10. Confidential PQRI Feedback Reports

CMS will provide confidential feedback reports on 2009 PQRI reporting to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. Access to confidential feedback reports may require eligible professionals to complete an identity-verification process. However, receipt of a report is not required to participate in the 2009 PQRI or to receive an incentive payment.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the eligible professionals who satisfactorily submitted data on quality measures under PQRI. Therefore, the names of eligible professionals who satisfactorily submitted data on quality measures for the 2009 PQRI will be posted on *http://www.medicare.gov* after the lump sum incentive payments are made in 2010.

C. E-Prescribing Incentive Program Overview

The E-Prescribing Incentive Program is a new and separate incentive program for eligible professionals who are successful e-prescribers as defined by the MIPPA. While this program has similarities to PQRI in structure and processes, it is a stand alone program with distinct reporting requirements and associated incentive payment.

1. Eligible Professionals

For the 2009 E-Prescribing Incentive Program, "eligible professional" includes the following:

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. 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

In order to participate in this incentive program, a professional in one of these categories must be authorized by his or her respective state laws to prescribe medication and prescribing medications must fall within the individual eligible professional's scope of practice.

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 E-Prescribing Incentive Program, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons.

Professionals eligible to participate but not able to participate include:

1. Professionals paid under or based upon the MPFS billing Medicare Carriers or Medicare Administrative Contractors (MACs) who do not bill directly. For example, Qualified Speech-Language Therapists do not currently bill Medicare directly. It is anticipated that Qualified Speech-Language Therapists will begin billing Medicare directly on July 1, 2009 at which point they would be able to participate.

2. Professionals paid under the MPFS billing Medicare fiscal intermediaries (FIs) or 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 FI/MAC 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.

Professionals not eligible to participate in the E-Prescribing Incentive Program and not able to qualify to earn an incentive payment include:

1. Those that are not defined as eligible professionals in the Medicare Improvements for Patients and Providers Act of 2008.

2. Services payable under fee schedules or methodologies other than the MPFS are not included in E-Prescribing Incentive Program (for example, services provided by federally qualified health centers, clinical

laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

3. Suppliers of durable medical equipment (DME) are not eligible for the E-Prescribing Incentive Program since DME is not paid under the MPFS.

2. Form and Manner of Reporting

Claims-based Reporting

For 2009, participation in the E-Prescribing Incentive Program is limited to the submission of quality data codes for the e-prescribing measure through Medicare's claims processing system, as described in the 2009 MPFS final rule with comment period.

There is no need to enroll or register to begin claims-based reporting for the 2009 E-Prescribing Incentive Program.

Participating eligible professionals who bill for the services or procedures included in the denominator of the 2009 e-prescribing measure will report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the 2009 e-prescribing measure are available on the CMS E-Prescribing Incentive Program website at *http://www.cms.hhs.gov/ERXIncentive*.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the billable service or procedure to which the quality-data code applies. The 2009 e-prescribing measure does not require a specific diagnosis to help determine the denominator; therefore, any diagnosis reported on the claim will be sufficient. The analysis algorithms that will be used to determine whether an eligible professional is a "successful e-prescriber" match the quality-data codes to the service and/or procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable service and/or procedure codes will not count toward an eligible professional meeting the requirements of being a "successful e-prescriber."

3. Reporting Periods

For 2009, the reporting period for the E-Prescribing Incentive Program is the entire calendar year, or January 1, 2009 – December 31, 2009.

4. Payment for Reporting

For 2009, eligible professionals who are determined to be "successful e-prescribers" (as discussed below) may earn an incentive payment equal to 2.0 percent of the total estimated allowed charges for all such MPFS covered professional services: (1) furnished by the eligible professional during the reporting period of January 1 through December 31, 2009, (2) received into the CMS NCH file by February 28, 2010, and (3) paid under or based upon the MPFS. Because claims processing times may vary by time of the year and Medicare Carrier/ MAC, participating eligible professionals should submit claims service dates late in 2009 promptly, so that those claims will reach the NCH file by February 28, 2010. CMS anticipates that the e-prescribing incentive payments will be paid as a lump sum in mid-2010. There is no beneficiary co-payment or notice to the beneficiary regarding the e-prescribing incentive payments.

According to the statute, however, there is a limitation with regard to the application of the incentive. For 2009, the incentive **does not** apply to eligible professionals, for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the e-prescribing measure applies are less than 10% of the total of the allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional. Under the E-Prescribing Incentive Program, covered professional services are those paid under or based upon the MPFS.

The e-prescribing incentive payment will apply to allowed charges for all covered professional services, not just those charges associated with the e-prescribing measure. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the MPFS amounts for assigned and non-assigned claims will not apply to the incentive. The statute defines e-prescribing covered services as those paid under or based upon the MPFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the MPFS do not apply to the e-prescribing incentive payment.

For 2009, the analysis of determining successful e-prescribers will be performed at the individual eligible professional level using individual-level NPI data. CMS, however, will use the TIN as the billing unit, so any e-prescribing incentive payments earned will be paid to the TIN holder of record. E-prescribing incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the e-prescribing incentive payment under more than one TIN will receive a separate e-prescribing incentive payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, section 1848(m)(2)(A) of the Act specifies that any e-prescribing incentive payment earned will be paid to the employers or facilities.

5. Determination of a Successful E-Prescriber
For purposes of qualifying for the e-prescribing incentive payment for 2009, an eligible professional will be considered a successful e-prescriber if he/she reported the applicable e-prescribing quality measure in at least 50 percent of the cases in which such measure is reportable by the eligible professional during the reporting period.

6. Confidential Feedback Reports
CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. Access to confidential feedback reports may require eligible professionals to complete an identity-verification process. Receipt of a report is not required to participate in the 2009 E-Prescribing Incentive Program or to receive an incentive payment.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the eligible professionals who are successful e-prescribers. Therefore, the names of eligible professionals who are determined to be successful e-prescribers for the 2009 E-Prescribing Incentive Program will be posted on *http://www.medicare.gov* after the lump sum incentive payments are made in 2010.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
6394.1	Contractors shall use this document for educational purposes.	X			X						
6394.2	Contractors shall comply with the policy described in sections B and C of this change request (above). **NOTE:** As a reminder, contractors are to allow PQRI codes to be processed and denied with the PQRI denial message when billed by any eligible professional described in the Policy section of this change request.	X			X						

III. PROVIDER EDUCATION TABLE

]

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6394.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Diane Stern, diane.stern@cms.hhs.gov, (410) 786-1133

Post-Implementation Contact(s): Aucha Prachanronarong, Aucha.Prachanronarong@cms.hhs.gov, (410) 786-1879

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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.