Quick-Reference Guide for Understanding the

2012 Electronic Prescribing (eRx) Payment Adjustment

This document describes how the 2012 eRx payment adjustment was 1) assessed and 2) applied for individual eligible professionals and self-nominated and CMS-selected group practices participating in the eRx Group Practice Reporting Option (GPRO).

Background

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (P.L.110-275) (MIPPA) requires the Centers for Medicare & Medicaid Services (CMS) to subject eligible professionals who are not successful electronic prescribers under the 2011 eRx Incentive Program to a payment adjustment in 2012.

All eligible professionals had the opportunity to avoid the 2012 eRx payment adjustment by meeting the criteria for becoming a successful electronic prescriber for purposes of the 2012 eRx payment adjustment.

To avoid the 2012 eRx payment adjustment, an eligible professional had to submit valid 2011 eRx G-codes (also known as quality-data codes or QDCs) for Medicare Part B PFS services via a CMS-1500 type claim form. Valid 2011 eRx QDCs/G-codes indicated that the eligible professional submitted a valid electronic prescription, met criteria for a hardship exemption, or did not have prescribing privileges during the 6-month reporting period (January 1–June 30, 2011) that were processed into the National Claims History (NCH) file by July 29, 2011.

2012 eRx Payment Adjustment

Assessment

- ***An eligible professional*** (TIN/NPI) who meets the 2011 eRx Program inclusion criteria (see MLN SE1107 at http://www.cms.gov/ERxIncentive/09_Educational_Resources.asp) will be subject to the 2012 eRx payment adjustment if (s)he did **not** submit the following:
  - 10 valid 2011 eRx G-codes (G8553) via claims during the 6-month reporting period; or
  - a hardship exemption G-code (G8642, G8643) via claims during the 6-month reporting period; or
  - a G-code via claims indicating (s)he did not have prescribing privileges (G8644) during the 6-month reporting period; or
  - (s)he requested and was granted a hardship exemption through the Quality Reporting Communication Support Page.

  CMS analysis of all valid 2011 eRx denominator-eligible QDCs/G-codes (G8553) submitted with a date of service during the 6-month reporting period determines whether or not the payment adjustment applies to the eligible professional, unless the eligible professional requested and was granted a hardship exemption.

- ***Group practices participating in eRx GPRO*** (self-nominated and CMS-selected group practices participating in eRx GPRO and reporting under the TIN) who would be subject to the payment adjustment is defined as a TIN who:
  - failed to meet the 2011 eRx criteria for successful reporting via claims based upon the group's size during the 6-month reporting period; or
  - failed to indicate a hardship or lack of prescribing privileges to CMS during self-nomination or vetting; or
  - requested and was denied a hardship exemption after sending a letter to CMS indicating their hardship exemption request (must have been postmarked by November 1, 2011).

  For group practices participating in eRx GPRO, the analysis of successful reporting among the group will be performed at the TIN level to identify the group's services and quality data during the 6-month reporting period. All NPIs under the TIN during the 2011 6-month reporting period (January 1, 2011 – June 30, 2011) will receive the payment adjustment if the eRx GPRO fails.

- For ***eligible professionals who submitted claims under multiple TINs***, CMS groups claims by TIN/NPI for analysis and payment adjustment purposes.
  - As a result, an eligible professional who submitted claims under multiple TINs may be subject to an eRx payment adjustment under one of the TINs and not the other(s), or may be subject to a payment adjustment under each TIN.

2012 eRx Payment Adjustment
Application

- The eRx payment adjustment (applied for not being a successful electronic prescriber) will result in an individual eligible professional, or group practices participating in eRx GPRO, receiving 99% of his or her Medicare Part B PFS amount that would otherwise apply to such services (or 1.0% less reimbursement) for all charges with a date of service from January 1–December 31, 2012.

- Providers receiving the 2012 eRx payment adjustment will see the indicator "LE" on their Remittance Advice for all Medicare Part B services rendered from January 1–December 31, 2012. The remittance advice will also contain the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):
  - CARC 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
  - RARC N545 – Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.

- The TIN/NPI (or eRx GPRO TIN) will receive automatically adjusted 2012 Medicare Part B reimbursements as (s)he would normally receive payment for Medicare Part B PFS covered professional services furnished to Medicare beneficiaries.

- The 2012 eRx payment adjustment will be applied separately from the 2011 eRx Incentive Program or any other CMS incentive program payments.

- If a TIN/NPI or eRx GPRO TIN submits claims to multiple Medicare claims processing contractors (Carriers or Medicare Administrative Contractors [MACs]) and is subject to the 2012 eRx payment adjustment, each contractor will pay out 1% less for all the Medicare Part B PFS claims the contractor processes with a date of service from January 1–December 31, 2012.

2012 eRx Payment Adjustment
Additional Information

- For further information related to the 2012 eRx payment adjustment, please refer to the Payment Adjustment Information section on the CMS eRx Incentive Program website at http://www.cms.gov/ERxIncentive and MLN document SE1107 at http://www.cms.gov/MLNMattersArticles/downloads/SE1107.pdf.

- If the TIN/NPI is not subject to the eRx payment adjustment and does see a payment adjustment, contact the QualityNet Help Desk. In the event that the TIN/NPI or eRx GPRO TIN receives the payment adjustment in error, the claim will be reprocessed to return the 1.0% and the remittance advice for the reprocessed claim will include the following codes and messages:
  - CARC 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
  - RARC N546 – Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.

- If the TIN/NPI or eRx GPRO TIN is subject to the payment adjustment and the adjusted amount received does not match 1.0% less than his/her standard reimbursement, contact the Carrier or MAC. Also see FAQ #10560.

- If an individual eligible professional (TIN/NPI) or group practice participating in eRx GPRO (GPRO TIN) submitted eRx QDC/G-code G8553 indicating a valid eRx event in addition to submitting a hardship or lack of prescribing privileges code (or notifies CMS of a hardship or lack of prescribing privileges for GPROs), the hardship/lack of prescribing privileges will take precedence.

- If the eligible professional is enrolled in Medicare, but does not "participate" (non-PAR) by accepting Medicare's allowed charge for services provided, (s)he should contact his/her Part B Carrier or MAC for instruction on how the 2012 eRx payment adjustment will be applied and the amount (s)he can initially charge the beneficiary when the service is provided. Also see FAQ #10561.

Questions?

For more information, see posted FAQs related to the eRx payment adjustment on the CMS web site at http://www.cms.gov/ERxIncentive.

Contact the **QualityNet Help Desk** at **1-866-288-8912** (TTY 1-877-715-6222) or qnetsupport@sdps.org Monday-Friday from 7:00 a.m. to 7:00 p.m. CST.

Appendix A

Resources/Key Terms as Used in the 2012 eRx Payment Adjustment Analysis and Documentation

Identified Inclusions for Medicare Part B PFS Total Estimated Allowed Charges:

- First expense and last expense dates were between January 1, 2011 and June 30, 2011 for the 6-month reporting period
- Claims-based measure NCH processing date must be on or before July 29, 2011
- Claims must be marked as "final" in the Part B claims database
- Split claims in the NCH file Healthcare Common Procedure Coding System (HCPCS) service lines were rejoined
- Line-items identified by HCPCS and modifier(s)
- Technical components of diagnostic services and anesthesia services (note: radiopharmaceuticals will be included in the basis of total estimated allowed charges on which the 1.0% incentive was calculated)

Identified Exclusions for Medicare Part B PFS Total Estimated Allowed Charges:

- Denied claims or denied line items
- Amount billed above the PFS for assigned and non-assigned claims
- Services payable under fee schedules or methodologies other than the Medicare Part B PFS were not included in eRx (refer to information on eligible professionals at http://www.cms.gov/ERxIncentive/05_Eligible%20Professionals.asp)

Medicare Part B PFS Total Estimated Allowed Charges

For more information on the PFS and Physician Reimbursement Rules, please refer to the CMS website at http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf.

NPI – National Provider Identifier

The individual rendering NPI representing the eligible professional was used to analyze claims in the January-June 2011 reporting period.

TIN – Taxpayer Identification Number or Tax ID Number

For eRx, "TIN" includes all of the following types of identifiers used by providers to submit claims to CMS:

1) Individual Social Security Number/Social Security Account Number (SSN/SSAN);
2) Employer Identification Number (EIN), also known as a "Tax ID Number", typically held by businesses or other organizations with employees; and
3) Individual Taxpayer Identification Number (I-TIN), issued by the IRS to individuals who do not need an EIN and do not wish to use their individual SSN/SSAN for certain business transactions.

TIN/NPI
The key unit of analysis for the individual eligible professional that was used to determine eligibility for the 2012 eRx payment adjustment was the individual NPI within a TIN. The TIN used in CMS' analysis is the Federal Tax ID # entered by the provider on submitted Part B claims. *(If an individual eligible professional furnished services for which reimbursement was claimed under more than one TIN, the eligible professional's eRx reporting rates and allowed charges were analyzed under each TIN separately.)*

Valid Instance of eRx Reporting
An eRx measure's quality-data code (QDC/G-code) submitted on a claim that also contained any combination of applicable CPT Category I service code(s) that defines a reportable instance for the measure, as identified by the measure's detailed specifications. *(The full, detailed specifications for the 2011 eRx measure, as implemented in 2011, are available for download from the CMS eRx web site)*.

- *2011 eRx Measure Specification* can be found at http://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp
- *2011 eRx Measure Specification for 2011 eRx GPRO* can be found at http://www.cms.gov/ERxIncentive/07_Group_Practice_Reporting_Option.asp