



Coding and Reporting Principles for the Electronic Prescribing (E-Prescribing) Incentive Programs – JA6514B

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Note: JA6514B was revised to add a link to MLN Matters® article SE1021 (<http://www.cms.gov/MLN/MattersArticles/downloads/se1021.pdf>) for the latest information on participating in the PQRI and E-Prescribing Incentive Program.

Key Words MM6514, CR6514, R513OTN, E-Prescribing

Contractors Affected

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers

Provider Types Affected Physicians and practitioners (referred to as eligible professionals (EPs)) who wish to participate in the E-Prescribing Incentive programs in 2009



Change Request (CR) 6514 provides a high-level overview of the coding and reporting principles for the claims-based reporting of quality measures data for the 2009 Physician Quality Reporting Initiative and for the claims-based reporting of the E-Prescribing measure for the 2009 E-Prescribing Incentive Program.

Note: There is another Job Aid (JA6514A) associated with CR6514 that addresses the coding and reporting principles for the PQRI.

E-Prescribing Incentive Programs Coding and Reporting Principles

Provider Needs to Know...

- To be considered a successful e-prescriber for 2009, an EP must report an E-Prescribing measure on at least 50% of reportable cases and at least 10% of an EP's total allowed Medicare Part B charges must come from the services delineated in the measure's denominator. For 2009, the E-Prescribing measure may be reported via

claims only.

Claims-based Reporting

- The E-Prescribing measure consists of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population for whom care was delivered using a particular structural element.
- Claims-based reporting of the E-Prescribing measure requires EPs, using their individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable PFS charges, to report the quality action for the E-Prescribing measure.

Program Documents/Educational Resources

- EPs should review the following documents if they choose to participate in the E- Prescribing Incentive Program:
 - "*E-Prescribing Measure Specifications*";
 - "*Claims-based Reporting Principles for E-Prescribing*" – This provides guidance about how to report the E- Prescribing measure on claims; and
 - "*Sample E- Prescribing Claim*" – This provides a detailed sample of an individual NPI reporting the E- Prescribing measure on a CMS-1500 claim.
- EPs can find these documents on the E- Prescribing Measure section page of the E- Prescribing Incentive Website at <http://www.cms.hhs.gov/ERXIncentive> on the CMS website.
- EPs can find educational resources to assist them in successfully participating in the E- Prescribing Incentive Program on the Educational Resources section page of the E- Prescribing Incentive Website at http://www.cms.hhs.gov/ERXIncentive/09_Educational_Resources.asp#TopOfPage on the CMS website.

Quality-Data Codes (QDCs)

- QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified Current Procedural Terminology (CPT) Category II codes and/or G-codes that describe the quality action required by a measure's numerator.
- Quality actions can apply to more than one condition. Therefore, they can also apply to more than one measure.
- Where necessary to avoid shared CPT Category II codes, G-codes should be used to distinguish quality actions across measures.
- Some measures require more than one quality action and therefore, have more than one CPT Category II code (G-code) or a combination associated with them.

Claims-based Reporting Principles

- The following principles apply for claims-based reporting of the E- Prescribing measure:
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1. EPs should report one of the three E-Prescribing codes listed below as the claim numerator:
 - G8443 - "All prescriptions created during the encounter were generated using a qualified E-Prescribing system";
 - G8445 - "No prescriptions were generated during the encounter"; and
 - G8446 - "Provider does have access to a qualified E-Prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the state or federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."
 2. EPs must report the E-Prescribing code (which supplies the numerator):
 - On the same claim as the denominator billing code;
 - For the same beneficiary;
 - For the same date of service; and
 - By the same EP (individual NPI) who performed the covered service.
 3. EPs must submit the E-Prescribing code 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 E-Prescribing code line is denied and tracked.
 - E-Prescribing line items will be denied for payment, but are passed through the claims processing system to Medicare's National Claims History (NCH) database, which is used for E-Prescribing claims analysis. EPs will receive a RA, which includes a standard remark code (N365).

The N365 remark code does **NOT** indicate whether the E-Prescribing code is accurate for that claim or for the measure that the EP is attempting to report. N365 only indicates that the E-Prescribing code passed into NCH. N365 reads, "This procedure code is not payable. It is for reporting/information purposes only."
 4. 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).
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5. Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an E- Prescribing code.

Submission through Carriers/MACs

- EPs may submit E-Prescribing codes to carriers/MACs either through electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or paper-based submission using the CMS-1500 claim form.

Electronic Submission

- When using electronic submission EPs:
 - Should submit the E-Prescribing codes in the SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop;
 - Will need 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;
 - Should submit diagnosis codes 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; and
 - In general for group billing, should report the NPI for the rendering provider in Loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data elements NM108 and NM109.

Paper-based Submission

- When using paper-based submissions EPs should:
 - Use the CMS-1500 claim form (Version 08-05) and enter relevant International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis codes in Field 21;
 - Enter service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers in Field 24D with a single reference number in the diagnosis pointer Field 24E that corresponds with the diagnosis number in Field 21; and
 - For group billing, enter the NPI of the rendering/performing provider in **Field 24J** and the Taxpayer Identification Number of the employer is entered in **Field 25**.

Timeliness of Quality Data Submission

- Claims processed by the Medicare Carrier/MAC must reach the Medicare NCH file by February 28, 2010, to be included in the analysis.
 - Claims that are resubmitted only to add QDCs will not be included in the analysis.
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Background

Section 132 of the Medicare Improvements for Patients and Providers Act (MIPPA) authorizes a new and separate incentive program for EPs who are successful E-Prescribers as defined by MIPPA. This new incentive is separate from, and in addition to, the PQRI.

**Operational
Impact**

N/A

**Reference
Materials**

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6514.pdf> on the CMS website.

The official instruction (CR6514) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R513OTN.pdf> on the CMS website.
