Claims-Based Reporting Principles for
2012 Electronic Prescribing (eRx) Incentive Program

This document is intended for those individual eligible professionals or group practices who self-nominated and were selected to participate in the eRx Incentive Program through the Physician Quality Reporting Group Practice Reporting Option (or eRx GPRO) who will be reporting the eRx measure via claims.

eRx GPROs should submit their intention and method to report the eRx measure, or request a significant hardship to avoid future eRx payment adjustment in their self nomination letter. Individual eligible professionals should refer to the Electronic Prescribing (eRx) Incentive Program Understanding Future Payment Adjustment *document for further information on the hardship exemptions and future payment adjustments. Individual eligible professionals and eRx GPROs should refer to their specific* 2012 eRx Measure Specification *for information on how to earn a 2012 eRx Incentive Program incentive payment.*

For successful reporting under the 2012 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 (faxes do not count)

- 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 2012 eRx incentive payment; **OR** on the claim(s) with any billing code(s) that represent the encounter to avoid the 2013 eRx payment adjustment
    - 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 CPT Category I or HCPCS codes, which supply the denominator

      NOTE: For purposes of reporting the eRx G-code to avoid the 2013 eRx payment adjustment, the eRx G-code can be reported on the claim(s) during the reporting period, regardless of whether the code for such service appears in 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, such as $0.01, can be substituted - the beneficiary is not liable for this nominal amount.
    - Whether a $0.00 charge or a nominal amount is submitted to the Carrier/Medicare Administrative Contractor (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 the NCH.
- If the entire claim is rejected, please review claim for errors before re-submitting. eRx G-codes will not be processed or tracked if the claim is rejected.

- When a group bills, the group National Provider Identifier (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 5010); or
- Paper-based submission, using the CMS-1500 claim form

Electronic-based Submission:
Physician Quality Reporting QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 5010)**, should follow the current HIPAA standard version of the ASC x12 technical report 3.

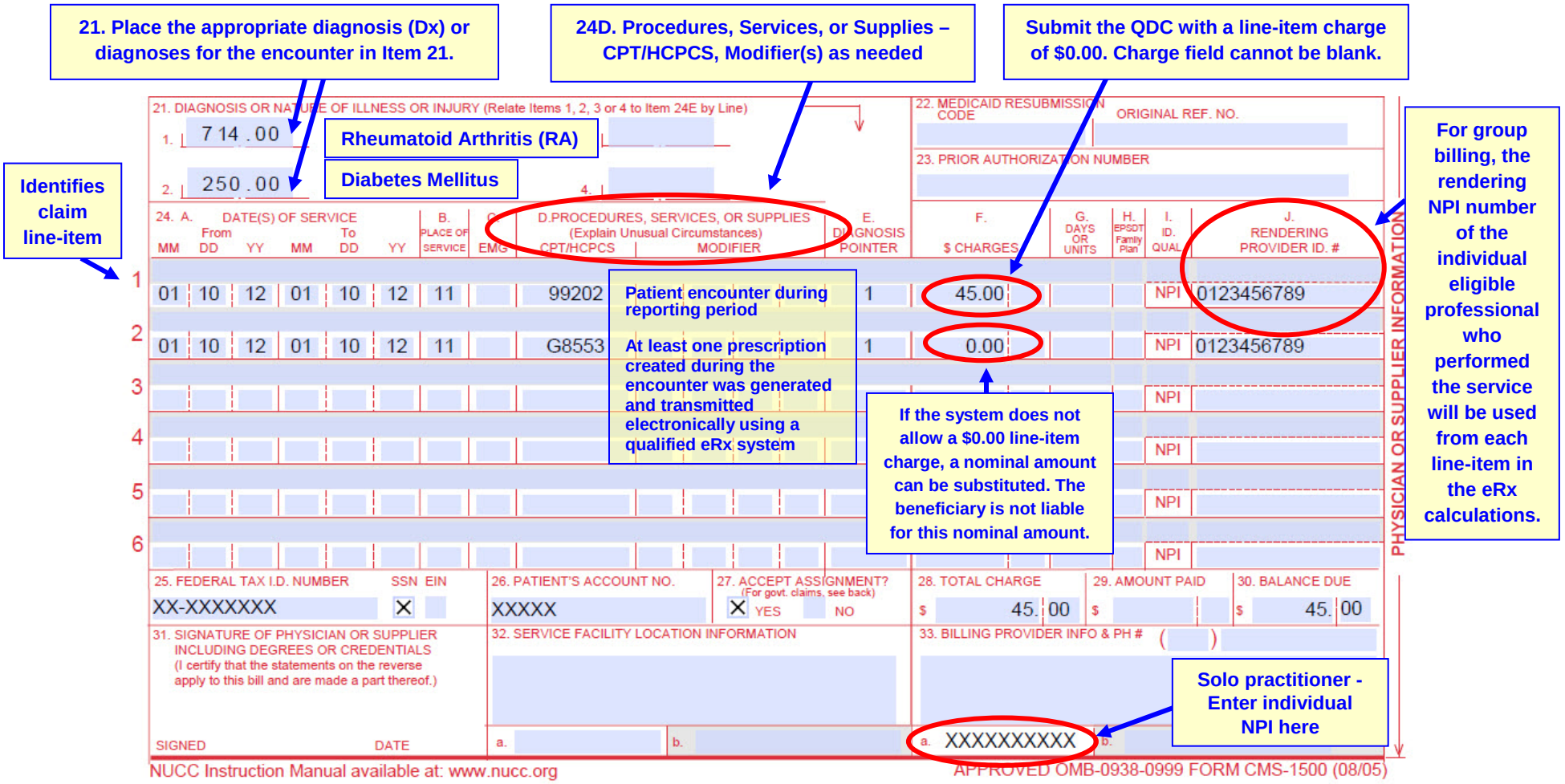
OR

Paper-based Submission:
Paper-based submissions are accomplished using the **CMS-1500 claim form (version 08-05)** as described in the sample claim provided in Appendix D.

Timeliness of Quality Data Submission
Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (NCH file) by **February 22, 2013** to be included in 2012 eRx Incentive Program 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 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.