Quick-Reference Guide for Understanding the 2014 Electronic Prescribing (eRx) Payment Adjustment

Purpose

This document describes how the 2014 eRx payment adjustment was 1) assessed and 2) applied for individual eligible professionals (EPs) and group practices participating in the eRx Group Practice Reporting Option (GPRO).

Background

Section 1848(a)(5) of the Social Security Act requires the Centers for Medicare & Medicaid Services (CMS) to subject EPs who are not successful electronic prescribers under the 2012 or 2013 eRx Incentive Program to a payment adjustment in 2014. A list of those professionals who are eligible and able to participate in the eRx Incentive Program for purposes of the incentive payment and payment adjustment is available on the CMS eRx Incentive Program website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive. All EPs had the opportunity to avoid the 2014 eRx payment adjustment by meeting the criteria for becoming a successful electronic prescriber, or by requesting a hardship exemption or lack of prescribing privileges hardship for purposes of the 2014 eRx payment adjustment.

Individual EPs and group practices participating in eRx GPRO had two opportunities to avoid the 2014 eRx payment adjustment by meeting the specified reporting requirements during the 2012 eRx 12-month reporting period (January 1-December 31, 2012) ***or*** during the 2013 eRx 6-month reporting period (January 1-June 30, 2013). For complete information on the eRx Incentive Program reporting options and inclusion criteria please refer to the resources listed in Appendix A, or the *2013 eRx Incentive Program: 2014 Payment Adjustment* document located on the CMS eRx website under the "Payment Adjustment Information" link.

Valid eRx Incentive Program events were counted when the eRx measure quality-data code (QDC or G-code) G8553 was submitted via claims, or reported through a qualified registry or qualified EHR system, and all measure-eligibility criteria were met (i.e., correct Current Procedural Terminology, or CPT code if applicable).

Valid 2012 eRx QDCs indicated that the EP successfully submitted and reported an electronic prescription for a denominator-eligible event as outlined in the *2012 eRx Measure Specification* available on the CMS eRx Incentive Program website under the "Electronic Prescribing Measure" link.

Valid 2013 eRx QDCs indicated that the EP completed one of the following actions as outlined in *2013 eRx Incentive Program: 2014 Payment Adjustment*:

- successfully submitted and reported eRx events for the required number of billable Medicare Part B Physician Fee Schedule (PFS) services;
- met criteria and successfully reported a hardship exemption via claims (G8642 or G8643); ***or***
- successfully reported that (s)he did not have prescribing privileges (G8644) via claims.

2014 eRx Payment Adjustment - Assessment

Individual Eligible Professional
Those who met the 2012 or 2013 eRx Incentive Program inclusion criteria will be subject to the 2014 eRx payment adjustment if (s)he:

- failed to submit 25 valid 2012 eRx G-codes (G8553) for denominator-eligible events via the appropriate reporting method (claims, qualified registry, or certified electronic health record [EHR]) during the 2012 eRx 12-month reporting period; ***or***
- failed to submit 10 valid 2013 eRx G-codes (G8553) for any billable Part B PFS service via claims during the 2013 eRx 6-month reporting period; ***or***
- failed to submit a hardship exemption G-code (G8642, G8643) via claims during the 2013 eRx 6-month reporting period; ***or***
- failed to submit a G-code via claims indicating (s)he did not have prescribing privileges (G8644) during the 2013 eRx 6-month reporting period; ***or***
- failed to request a 2014 eRx payment adjustment hardship exemption through the Communication Support Page; ***or***
- requested a 2014 eRx payment adjustment hardship exemption through the Communication Support Page, but the request was denied.

CMS' analysis of all valid 2012 or 2013 eRx quality-data codes (QDCs/G-codes) submitted with a date of service during the eRx 12- or 6-month reporting period determines whether or not the payment adjustment applies to the EP, unless the EP requested and was granted a hardship exemption.

CMS will determine whether an individual EP (defined by individual rendering National Provider Identifier, or NPI) is subject to a payment adjustments for each Tax Identification Number (TIN). Therefore, analysis for individual EPs is conducted at a TIN/NPI level.

eRx GPRO
Those group practices who self-nominated to participate in eRx GPRO and reported under the TIN would be subject to the payment adjustment if the group:

- failed to meet the 2012 eRx criteria for successful reporting via the self-selected reporting method (claims, qualified registry, or certified electronic health record [EHR]) based upon the group's size during the eRx 12-month reporting period; ***or***
- failed to meet the 2013 eRx criteria for successful reporting via claims based upon the group's size during the eRx 6-month reporting period; ***or***
- failed to indicate a hardship or lack of prescribing privileges to CMS during self-nomination or vetting; ***or***
- failed to request a 2014 eRx payment adjustment hardship exemption through the Communication Support Page; ***or***
- requested a 2014 eRx payment adjustment hardship exemption through the Communication Support Page, but the request was denied.

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 2012 eRx 12-month reporting period or the 2013 eRx 6-month reporting period.

EPs Who Submitted Claims Under Multiple TINs
CMS groups claims by TIN/NPI for analysis and payment adjustment purposes. As a result, an EP 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.

2014 eRx Payment Adjustment Application

- The eRx payment adjustment (applied for not being a successful electronic prescriber) will result in an individual EP, or group practice participating in eRx GPRO, receiving 98.0% of his or her Medicare Part B PFS allowed charges amount that would otherwise apply to such services (or 2.0% less reimbursement) for all charges with dates of service from January 1–December 31, 2014.

- Individual EPs and group practices receiving the 2014 eRx payment adjustment will see the indicator "LE" on their Remittance Advice for all Medicare Part B services rendered from January 1–December 31, 2014. 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 National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
  - RARC N545 – Payment reduced based on status as an unsuccessful electronic prescriber per the Electronic Prescribing (eRx) Incentive Program.

- The individual EP or group practice participating in eRx GPRO will receive automatically adjusted 2014 Medicare Part B PFS reimbursements as (s)he would normally receive payment for Medicare Part B PFS covered professional services furnished to Medicare beneficiaries.

- The 2014 eRx payment adjustment will be applied separately from the 2013 eRx Incentive Program incentive payment or any other CMS incentive program payments.

- If an individual EP or group practice participating in eRx GPRO submits claims to multiple Medicare claims processing contractors (Carriers or A/B Medicare Administrative Contractors [MACs]) and is subject to the 2014 eRx payment adjustment, each contractor will pay out 2.0% less for all the Medicare Part B PFS claims the contractor processes with dates of service from January 1–December 31, 2014.

2014 eRx Payment Adjustment Additional Information

- For further information related to the 2014 eRx payment adjustment, please refer to the Payment Adjustment Information section on the CMS eRx Incentive Program website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive and the *2013 eRx Incentive Program: 2014 Payment Adjustment* tip sheet at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Downloads/2013SE13__eRx2014PaymentAdjustment_072613.pdf.

- EPs or group practices who participated in eRx GPRO can request an informal review if they were notified of being subject to the 2014 eRx payment adjustment. Informal review requests can be submitted to eRxInformalReview@cms.hhs.gov *through February 28, 2014.*
  - Also see the *2014 eRx Payment Adjustment Informal Review Made Simple* at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/20_Payment_Adjustment_Information.html.

If the individual EP or group practice participating in eRx GPRO is not subject to the eRx payment adjustment and does see a payment adjustment, contact the QualityNet Help Desk. In the event that the individual EP or group practice receives the payment adjustment in error, the claim will be reprocessed to return the 2.0% 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 individual EP or group practice participating in eRx GPRO is subject to the payment adjustment and the adjusted amount received does not match 2.0% less than his/her standard reimbursement, contact the Carrier or A/B MAC. Also see Frequently Asked Question (FAQ) #3161 at https://questions.cms.gov/.

- If an individual EP (TIN/NPI) or group practice (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 the group practice), the hardship/lack of prescribing privileges will take precedence.

- If the EP 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 A/B MAC for instruction on how the 2014 eRx payment adjustment will be applied and the amount (s)he can initially charge the beneficiary when the service is provided. Also see FAQ #3163.

Questions?

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

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 2014 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, 2012 and December 31, 2012 for the eRx 12-month reporting period and between January 1, 2013 and June 30, 2013 for the eRx 6-month reporting period.
- Claims processing date into the National Claims History file (NCH) must be on or before February 22, 2013 for the 2012 eRx 12-month reporting period, and on or before July 26, 2013 for the 2013 eRx 6-month reporting period.
- Claims must be marked as "final" in the Part B PFS 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)

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

- Denied claims or denied line items
- Amounts 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 EPs at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive > Eligible Professionals)

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://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf.

NPI – National Provider Identifier

The individual rendering NPI representing the eligible professional was used to analyze services rendered during the January-December 2012 and/or January-June 2013 reporting periods.

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 2014 eRx payment adjustment was the individual NPI within a TIN. The TIN used in CMS' analysis is the Federal Tax ID number 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 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 2012 and 2013 eRx measures, as implemented in 2012 and 2013, are available for download from the CMS eRx web site. Note that measure specifications are updated each year; please ensure that the appropriate program year's documents are used.)*

- *2012 eRx Measure Specification* can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive > Electronic Prescribing Measure
- *2012 eRx GPRO Measure Specification* can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive > Group Practice Reporting Option
- *2013 eRx Measure Specification* can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive > Electronic Prescribing Measure
- *2013 eRx GPRO Measure Specification* can be found at > Group Practice Reporting Option