

# **CMS-Selected Group Practice Reporting Option (GPRO)**

Program Year 2012  
Monthly Support Call  
June 6, 2012

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# Your GPRO Support Team



## ❖ CMS

- Regina Reymann Chell, RN, BSN, GPRO Lead

## ❖ CMS Contractors

- Web Interface Development Team – “DECC”
  - Jane Schiemer, Application Architect
- Program Management and Measures Team – “PMBR”
  - Courtney Rose, Health Informatics Analyst
  - Kris Peters, Clinical Analyst
  - Carol Noyes, Clinical Analyst
- Vetting/Support Call Team – “Vetting Contractor”
  - Tom Campbell, Lead
  - Ann Bagchi, Lead
- QualityNet Help Desk

# Agenda



- ❖ Welcome
- ❖ Electronic Prescribing (eRx) Incentive Program
  - Incentive
  - Payment Adjustments
- ❖ Overview of Beneficiary Assignment & Sampling Process
- ❖ Upcoming Support Calls

# Requirements for eRx GPRO – 2012 Incentive



- ❖ eRx information in this section is specific to groups who self-nominated and were selected to participate in eRx GPRO
- ❖ If your eligible professionals are participating in eRx as individuals, please refer to the Individual eRx Measure Specifications:  
[http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/E-Prescribing\\_Measure.html](http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/E-Prescribing_Measure.html)

# Requirements for eRx GPRO – 2012 Incentive, cont.



## ❖ Reporting period

- January 1, 2012 to December 31, 2012

## ❖ Report via claims, qualified registry or qualified electronic health record (EHR) data submission vendor per self-nomination letter

- Cannot report GPRO eRx via EHR direct

## ❖ See the separate eRx GPRO measure specification:

[https://www.cms.gov/apps/ama/license.asp?file=/ERxIncentive/downloads/2012\\_GPROeRx\\_Measure\\_ReleaseNotes\\_ClaimsBasedRptgPrinciples\\_111011.zip](https://www.cms.gov/apps/ama/license.asp?file=/ERxIncentive/downloads/2012_GPROeRx_Measure_ReleaseNotes_ClaimsBasedRptgPrinciples_111011.zip)

# 2012 eRx GPRO Incentive



- ❖ Incentive payment of 1% of Part B Physician Fee Schedule (PFS) allowed charges for a successful group
- ❖ Adopt a qualified eRx system
- ❖ Successfully report for eligible eRx events
  - January 1, 2012 through December 31, 2012
    - Small GPROs:  $\geq 625$  unique encounters
    - Large GPROs:  $\geq 2,500$  unique encounters
- ❖  $\geq 10\%$  of total allowed charges must be for services in the measure denominator

# Successful eRx GPRO Submission Methods for Incentive



- ❖ Groups must participate in eRx GPRO for incentive via the method selected during self-nomination
- ❖ Claims reporting:
  - Submit denominator CPT code and numerator G-code (**G8553**) on the claim for requisite number of events by group size for encounters occurring between January 1 and December 31, 2012
- ❖ EHR Data Submission Vendor/Registry reporting:
  - Submit denominator CPT code and electronically generated and transmitted prescription for requisite number of events by group size for encounters occurring between January 1, 2012 and December 31, 2012

# Successful eRx GPRO Submission for Incentive, cont.



Reporting Mechanism	Group Size	Reporting Period	Criteria for Successful eRx Submission
Claims	25-99 Eligible Professionals	January 1, 2012 – December 31, 2012	Submit both a denominator CPT code and the numerator G-code (G8553) on the same claim representing the eligible encounter for at least 625 unique MPFS encounters.
Claims	100+ Eligible Professionals	January 1, 2012 – December 31, 2012	Submit both a denominator CPT code and the numerator G-code (G8553) on the same claim representing the eligible encounter for at least 2,500 unique MPFS encounters
Registry or EHR Data Submission Vendor	25-99 Eligible Professionals	January 1, 2012 – December 31, 2012	Submit a denominator CPT code and electronically generated and transmitted prescription (not faxed) for at least 625 unique MPFS encounters
Registry or EHR Data Submission Vendor	100+ Eligible Professionals	January 1, 2012 – December 31, 2012	Submit a denominator CPT code and electronically generated and transmitted prescription (not faxed) for at least 2,500 unique MPFS encounters

# 2013 eRx Payment Adjustment



- ❖ For group practices that do not meet eRx reporting criteria, the 2013 eRx payment adjustment of 1.5% will result in a group practice receiving 98.5% of their Medicare Part B PFS amount for covered professional services for dates of service January 1 through December 31, 2013
  - eRx GPROs are analyzed at the TIN level
    - If an eRx GPRO is unsuccessful at avoiding a payment adjustment, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment
  - Payment adjustment applies whether or not the group practice participates in the eRx Incentive Program or Health Information Technology for Economic and Clinical Health (HITECH) program

# 2013 eRx Payment Adjustment: GPRO Eligibility Criteria



- ❖ The 2013 eRx payment adjustment will only apply to those 2011 and/or 2012 eRx GPROs who meet ALL of the following criteria:
  - Had more than 10% of the eRx GPRO's allowed charges from January 1 to June 30, 2012 comprised of codes in the denominator of the 2012 eRx measure
  - Did not successfully report the required number of events via claims January 1 to June 30, 2012
  - Were not successful eRx GPRO for the 2011 eRx 12-month reporting period
  - Were not granted a 2013 eRx hardship exemption

# Avoiding 2013 eRx Payment Adjustment – GPRO



- ❖ Participate as an eRx GPRO

## **AND one of the following:**

- ❖ Selected as 2011 eRx GPRO and successfully electronically prescribed for 2011 eRx incentive
- ❖ Report required eRx events from January 1 to June 30, 2012 **via claims**
- ❖ Request and receive hardship exemption by June 30, 2012

# Avoiding 2013 eRx Payment Adjustment – GPRO, cont.



Group Size	Reporting Period	Reporting Mechanism	Criteria for Avoiding the 2013 eRx Payment Adjustment
25-99 Eligible Professionals	January 1, 2012 – June 30, 2012	Claims	Report G8553 <b>for at least 625 unique MPFS encounters</b> . The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, <u>regardless</u> of whether the claim contains coding in the eRx measure's denominator.
100+ Eligible Professionals	January 1, 2012 – June 30, 2012	Claims	Report G8553 <b>for at least 2,500 unique MPFS encounters</b> . The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, <u>regardless</u> of whether the claim contains coding in the eRx measure's denominator.

# Hardship Exemptions



- ❖ May be granted if CMS determines that compliance with eRx requirements would result in significant hardship
  - Reviewed on a case-by-case basis
  - Must be renewed annually

# Hardship Exemptions, cont.



- ❖ The following hardships may be submitted via the QNet Communications Support Page (CSP) (those with G-codes, may also be submitted via claims):
  - Inability to electronically prescribe due to local, state, or federal law, or regulation
  - Prescribed or expect to prescribe fewer than 100 prescriptions in the January 1 through June 30, 2012 reporting period
  - Practices in a rural area without sufficient high-speed Internet access (G8642)
  - Practices in an area without sufficient available pharmacies for electronic prescribing (G8643)
- ❖ The following exemption may only be submitted via claims:
  - Does not have prescribing privileges in the January 1 through June 30, 2012 reporting period (G8644)

# Hardship Exemptions, cont.



- ❖ Submit a hardship exemption request via the QNET CSP:  
[https://www.qualitynet.org/portal/server.pt/community/communications\\_support\\_system/234#](https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234#)
- ❖ Deadline for hardship request is **June 30, 2012**
  - **All decisions on significant hardship exemption requests will be final**
- ❖ Complete information on 2013 eRx payment adjustment hardship exemptions is available in *MLN Article SE1206* available on the CMS eRx website

# Avoiding the 2014 eRx Payment Adjustment



- ❖ Successfully submit the required number of eRx events in 2012
  - Will avoid the 2014 eRx payment adjustment and earn the 2012 eRx incentive

# Resources/Where to Begin



❖ Please visit CMS' eRx incentive website for additional information:  
<http://www.cms.gov/ERxincentive>

Medicare	Medicaid/CHIP	Medicare-Medicaid Coordination	Insurance Oversight	Innovation Center	Regulations and Guidance	Research, Statistics, Data and Systems	Outreach and Education
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## E-Prescribing Incentive Program

- [Spotlight](#)
- [How To Get Started](#)
- [Statute Regulations Program Instructions](#)
- [Eligible Professionals](#)
- [E-Prescribing Measure](#)
- [CMS-Selected Group Practice Reporting Option](#)**
- [Alternative Reporting Mechanism](#)
- [Educational Resources](#)
- [Analysis and Payment](#)
- [Help Desk Support](#)
- [Payment Adjustment Information](#)
- [2009 e-Rx Incentive Program](#)
- [2010 eRx Incentive Program](#)
- [2011 eRx Incentive Program](#)

## CMS-Selected Group Practice Reporting Option

In accordance with section 1848(m)(3)(C) of the Social Security Act (the Act), CMS is introducing a new group practice reporting option (GPRO) for the Electronic Prescribing (eRx) Incentive Program beginning with the 2010 eRx Incentive Program. Group practices that are successful electronic prescribers for a particular reporting period are eligible to earn an eRx incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period. For the 2010 eRx Incentive Program, the incentive payment is equal to 2% of the group practice's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the 2010 reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, an individual eligible professional who is a member of a group practice selected to participate in the eRx GPRO is not eligible to separately earn an eRx incentive payment as an individual eligible professional under that same Tax Identification Number (TIN) (that is, for the same TIN/National Provider Identifier, or NPI, combination). Once a group practice (TIN) is selected to participate in the GPRO, this is the only method of eRx reporting available to the group and all individual NPIs who bill Medicare under the group's TIN.

### 2012 eRx CMS-Selected GPRO

The eRx CMS-selected GPRO Measure has been updated for the 2012 eRx Program year. The measure may be reported through various reporting options. The file is named "2012 CMS-Selected GPRO eRx Measure Specifications, Release Notes and Claims Based Reporting Principles". The zip file contains three helpful documents:

1. [2012\\_eRx\\_GPROMeasureSpecification\\_111011.pdf](#) – Contains the eRx Measure Specification for the 2012 Program Year.
2. [2012\\_eRx\\_GPROMeasuresSpecification\\_ReleaseNotes\\_111011.pdf](#) – Details the changes made to the eRx Measure Specification since the 2011 Program Year.

# **Overview of 2012 Physician Quality Reporting System Beneficiary Assignment & Sampling<sup>1</sup>**

**1 Not applicable to Accountable Care Organizations (ACOs) and Physician Group Practices (PGPs). ACOs and PGPs should follow their own program guidance on PQRS and quality measures.**

# Introduction



- ❖ Future support calls will explain the Measures & Supporting Documents, Web Interface training, XML training, etc.
- ❖ Beneficiary assignment and sampling process for 2012 has been changed from 2010 and 2011, based on feedback from the groups and to align with the Physician Group Practice Transition Demonstration

# Criteria for Assignment



- ❖ Obtain list of potential beneficiaries by looking for all who had at least 2 face-to-face visits during the measurement period
- ❖ Look at all claims for those potential beneficiaries – even those claims outside of the GPRO TIN
- ❖ If office visits to general practice, family practice, internal medicine, or geriatric medicine at the GPRO are greater than those outside of the GPRO, then the beneficiary is assigned to the GPRO
- ❖ If there are no visits attributed to the four primary care physicians, then all providers will be considered

# Criteria for Assignment, cont.



- ❖ Assignment will attempt to remove beneficiary if he/she:
  - Had fewer than 2 visits or denominator eligible encounters
  - Only has a partial year of Medicare eligibility
  - Is deceased
  - Is a managed care beneficiary
  - Does not live in the US
  - Is in hospice care
  - Is considered working aged, ESRD, or working disabled
  - Does not have Medicare as a primary insurer
  - Is not enrolled in Medicare for the entire year
- ❖ The Web Interface provides the option to skip beneficiaries, as appropriate

# Criteria for Sampling



- ❖ Criteria for beneficiaries in assigned pool are used to determine eligibility in disease modules/patient care measures
- ❖ Beneficiaries are then randomly selected for disease module/patient care measures

# Criteria for Sampling, cont.



- ❖ GPROs will receive a sample of Medicare beneficiaries assigned to one or more disease modules or patient care measures
- ❖ Medicare Part B claims submitted with dates of service from January 1, 2012 through the last Friday in October of 2012 are analyzed by CMS
  - This does not mean the claim has to be processed by the last Friday in October
  - CMS randomly samples qualified Medicare beneficiary to group practice if practice provides the **plurality** of office/other outpatient services (minimum 2 visits)

# Criteria for Sampling, cont.



- ❖ The pool of assigned beneficiaries (up to 616 beneficiaries for a large GPRO and up to 327 beneficiaries for a small GPRO) is randomly selected and assigned to disease modules and patient care measures
- ❖ This represents an oversampling so the GPRO may complete measure information on at least 411 (as a large GPRO) or 218 (as a small GPRO) consecutively ranked beneficiaries
- ❖ A GPRO may not have enough beneficiaries who qualify for each disease module or patient care measure; if not, they must complete 100% of the beneficiaries in the sample for that module or patient care measure

# Criteria for Sampling, cont.



- ❖ Part A and B claims are reviewed to extract any information that may be useful in completing measure information
  - This data is pre-populated in the GPRO sample to assist the GPRO with measure completion
- ❖ During chart abstraction and measure completion, the GPRO may determine that the beneficiary should not be in the assigned module
- ❖ When possible, elements will be pre-filled from claims
  - ALL claims are used when pre-filling elements

# Disease Modules



- ❖ Chronic Obstructive Pulmonary Disease (COPD)
- ❖ Coronary Artery Disease (CAD)
- ❖ Diabetes Mellitus (DM)
- ❖ Heart Failure (HF)
- ❖ Hypertension (HTN)
- ❖ Ischemic Vascular Disease (IVD)

# Patient Care Measures



## ❖ Care Coordination/Patient Safety

- CARE-1: Medication Reconciliation
- CARE-2: Screen for Future Falls Risk

## ❖ Preventive Care

- PREV-5: Screening Mammography
- PREV-6: Colorectal Cancer Screening
- PREV-7: Influenza Immunization
- PREV-8: Pneumonia Vaccination
- PREV-9: BMI Screening
- PREV-10: Tobacco Use
- PREV-11: High Blood Pressure

## ❖ These measures are individually sampled

# Upcoming Support Calls



- ❖ July 11, 2012, 3-4 pm ET
- ❖ August 8, 2012, 3-4 pm ET
- ❖ September 5, 2012, 3-4 pm ET
- ❖ October 3, 2012, 3-4 pm ET
- ❖ November 7, 2012, 3-4 pm ET
- ❖ December 5, 2012, 3-4 pm ET

# If You Still Have Questions...



## ❖ QualityNet Help Desk

- Monday – Friday: 7:00 am - 7:00 pm CT
  - E-mail: [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org)
  - Phone: (866) 288-8912 (TTY 1-877-715-6222)
  - Fax: (888) 329-7377
- ❖ When calling the QualityNet Help Desk, please identify yourself as a 2012 GPRO participant
- ❖ Tickets may be escalated to the appropriate Tier in order to assist you