

FAQs for 6/21/11 National Provider Call

6/16/11

New FAQs on eRx/eRx Payment Adjustment

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Question #10407: If a resident electronically prescribes for a Medicare patient at an encounter, can the attending (teaching) physician report the Electronic Prescribing (eRx) Incentive Program G-code G8553 even if he/she was not the provider completing the electronic prescription?

Answer: For 2011 the answer is yes; it would be appropriate for the teaching physician to submit G8553 for eRx on the claim IF all of the following apply:

- The teaching physician provides a service involving a resident and a claim is submitted under the teaching physician's National Provider Identifier (NPI); **and**
- That encounter is listed in the denominator of the eRx measure; **and**
- The resident submits an electronic prescription using a qualified electronic prescribing system (as defined in the measure) during the encounter (even if the resident's NPI is on the prescription).

This eRx event would count toward the individual teaching physician's 25 unique eRx events reported for purposes of the eRx incentive (or 2,500 for Group Practice Reporting Option I or GPRO I; varies for GPRO II). This would also count toward the teaching physician's eRx events required for avoiding the 2012 and 2013 eRx Payment Adjustments.

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Question #10477: Can eligible professionals participate in the 2011 Physician Quality Reporting System (formerly called PQRI), 2011 Electronic Prescribing (eRx) Incentive Program, **and** the EHR Incentive Program (aka Meaningful Use) and earn incentives for each?

Answer: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

- If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also receive the eRx incentive.
- If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional. If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2012 eRx payment adjustment.

For questions on the Physician Quality Reporting System and eRx Incentive Program, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) from 7:00 a.m. - 7:00 pm. CST Monday through Friday or via Qnetsupport@sdps.org.

For more information, please see the CMS EHR Incentive Programs website at <http://www.cms.gov/EHRIncentivePrograms>. Questions on the EHR Incentive Program should be directed to the EHR Information Center at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number) from 7:30 a.m. - 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

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Question #10560: How will the Electronic Prescribing (eRx) payment adjustment apply to Medicare participating providers?

Answer: Irrespective of whether a physician is deemed participating or non-participating, the eRx payment adjustment will be applied to the allowed Medicare Physician Fee Schedule (MPFS) independently, before the beneficiary co-insurance is assessed. However, if the physician is subject to a payment adjustment due to his/her failure to be deemed a successful electronic prescriber under the eRx Incentive Program, the payment adjustment will be applied to the initial allowed MPFS.

Example: In calendar year 2012, the MPFS amount for a particular service is \$100. If the physician is not subject to a payment adjustment, the paid amount the physician will receive is \$80. That is, \$100 (allowed MPFS) - (\$100 x 20%)

(beneficiary co-pay) = \$80.00. The beneficiary co-insurance is 20% of the MPFS amount, or $\$100 \times 20\% = \20.00 . However, if the physician is subject to a 1.0% payment adjustment due to his/her failure to be deemed a successful electronic prescriber under the eRx Incentive Program, the 1.0% payment adjustment will be applied to the initial allowed MPFS. As such, the reduced MPFS is $\$100 - (\$100 \times 1.0\%) = \$99.00$. The beneficiary will pay $\$99.00 \times 20\% = \19.80 . The paid amount to the physician accounting for the payment adjustment will thus be $\$99.00 - \$19.80 = \$79.20$.

Note: Multiple Procedure Payment Reductions (MPPR) are calculated AFTER the application of the payment adjustment to the MPFS.

Below is a table which illustrates this example:

Participating physician NOT subject to 1.0% payment adjustment	Participating physician SUBJECT to 1.0% payment adjustment
Allowed MPFS = \$100	Allowed MPFS = \$100
MPFS with Payment Adjustment (PA MPFS) = $\$100 - \$0.00 = \$100$	MPFS with Payment Adjustment (PA MPFS) = $\$100 - (\$100 \times 1.0\%) = \$99.00$
Beneficiary co-pay = (Allowed MPFS) $\times 20\% = \$20$	Beneficiary co-pay = (PA MPFS) $\times 20\% = \$19.80$
Amount Paid to Physician = \$80	Amount Paid to Physician = \$79.20
[Allowed MPFS (\$100) - Beneficiary co-pay (\$20)]	[PA MPFS (\$99.00) - Beneficiary co-pay (\$19.80)]

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Question #10561: How will the Electronic Prescribing (eRx) payment adjustment apply to providers who do NOT participate with Medicare (accept Medicare assignment) ?

Answer: Irrespective of whether a physician is deemed participating or non-participating, the eRx payment adjustment will be applied to the allowed Medicare Physician Fee Schedule (MPFS) independently, before the beneficiary co-insurance is assessed. However, if the physician is subject to a payment adjustment due to his/her failure to be deemed a successful electronic prescriber under the eRx Incentive Program, the 1.0% payment adjustment will be applied to the initial allowed MPFS.

Example: In calendar year 2012, the MPFS amount for a particular service is \$100. The fee schedule amount is reduced by 5% for non-participating physicians, so the fee schedule in this example would be reduced to \$95.00. The non-participating physician may charge up to 115% of the approved fee schedule amount. Given these parameters, if the physician is not subject to a payment adjustment, the fee schedule amount remains at \$95.00. Thus, the non-participating physician may charge up to 115% of the approved fee schedule amount, or \$95.00 (approved fee schedule amount) $\times 115\% = \$109.25$. The amount paid to the beneficiary is 80% of the reduced MPFS = 80% of \$95.00 (approved fee schedule amount) = \$76.00. The beneficiary pays $\$109.25 - \$76.00 = \$33.25$.

However, if the physician is subject to a 1.0% payment adjustment due to his/her failure to be deemed a successful electronic prescriber under the eRx Incentive Program, the 1.0% payment adjustment will be applied to the initial allowed MPFS. As such, the MPFS with the applied payment adjustment is $\$95.00 - (\$100.00 \times 1\%) = \$94.00$. Therefore, if a 1.0% payment adjustment were applied to the non-participating physician, the non-participating physician may charge up to $\$94.00$ (approved fee schedule amount - payment adjustments) $\times 115\% = \$108.10$. The amount paid to the beneficiary would be $80\% \times \$94.00 = \75.20 . The beneficiary pays $\$108.10 - \$75.20 = \$32.90$.

Note: If the eRx payment adjustment applies to a physician, Multiple Procedure Payment Reductions (MPPR) are calculated AFTER the application of the payment adjustment to the MPFS. Below is a table which illustrates this example:

Non-participating physician NOT subject to 1.0% payment adjustment	Non-participating physician SUBJECT to 1.0% payment adjustment
Allowed MPFS = \$100	Allowed MPFS = \$100
Reduced MPFS for non-participating physician (R MPFS) = $\$100 - (\$100 \times 5.0\%) = \$95.00$	Reduced MPFS for non-participating physician (R MPFS) = $\$100 - (\$100 \times 5.0\%) = \$95.00$
MPFS with Payment Adjustment (PA MPFS) = $\$95.00 - \$0.00 = \$95.00$	MPFS with Payment Adjustment (PA MPFS) = $\$95.00 - (\$100.00 \times 1.0\%) = \$94.00$
Maximum amount non-participating physician may charge = (R MPFS $\times 115\%$) = \$109.25	Maximum amount non-participating physician may charge = (PA MPFS $\times 115\%$) = \$108.16
Amt paid to beneficiary = $80\% \times \$95.00 = \76.00	Amt paid to beneficiary = $80\% \times \$94.00 = \75.20
Beneficiary pays = $\$109.25 - \$76.00 = \$33.25$	Beneficiary pays = $\$108.16 - \$75.20 = \$32.90$

Question #10564: What are the reporting requirements for eligible professionals working under multiple Taxpayer Identification Numbers (TINs) who wish to avoid the 2012 Electronic Prescribing (eRx) Payment Adjustment?

Answer: Analysis of the 6-month claims reporting period in 2011 (January 1-June 30) to determine eligibility for the 2012 eRx Payment Adjustment is per the TIN/National Provider Identifier (NPI). An eligible professional will need to meet the reporting criteria for each TIN under which he or she worked under for the first 6 months of 2011.

In November 2010, the Centers for Medicare & Medicaid Services announced that eligible professionals who are not successful electronic prescribers in 2011 may be subject to a 1% payment adjustment in 2012 on their Medicare Part B Physician Fee Schedule (PFS) covered professional services. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program. An eligible professional will be subject to the 2012 eRx Payment Adjustment if he/she:

- Is a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES;
- Has prescribing privileges (Note: If not, (s)he must report (G8644) at least one time on an eligible claim prior to June 30, 2011 to indicate no prescribing privileges);
- Has at least 100 cases during the January-June 2011 period containing an encounter code in the eRx measure's denominator;
- Has more than 10% of his/her total allowed Part B PFS charges comprised of charges from the eRx measure's denominator during the January-June 2011 period; or
- Reports the eRx measure via claims for fewer than 10 unique eRx events during the January-June 2011 period for patients in the denominator of the measure.

Eligible professionals will need to report the eRx measure at least 10 times via claims during the first six months of 2011 in order to avoid the 2012 eRx Payment Adjustment.

CMS created two hardship codes to exempt providers from the eRx payment adjustment, if applicable. These include:

- G8642 - indicating the practice is in a rural location with limited broadband internet access (will need to enter it on at least one eligible claim); and
- G8643 - indicating the practice is in an area with limited pharmacies that can accept eRx (enter on at least one eligible claim).

To become a "successful electronic prescriber," ensure submission of the required number of eRx (10 for individual eligible professional/NPI under each TIN) via claims between January 1 and June 30, 2011 OR one of the hardship G-codes to avoid the payment adjustment in 2012.

Question #10626: In addition to new electronically generated prescriptions, do electronically generated prescription refills count toward the reporting requirements for the Electronic Prescribing (eRx) Incentive Program?

Answer: It depends on the circumstances. There must be a covered Medicare Physician Fee Schedule (PFS) service furnished during the reporting period at the time the prescription is electronically prescribed which meets the coding specified in the measure's denominator.

Electronically generated refills (using a qualified system) associated with a denominator-eligible face-to-face patient visit DO qualify as electronic prescribing. Electronically generated refills that are NOT associated with a face-to-face patient visit DO NOT qualify. New or refill prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count toward the minimum required eRx events.

To be a successful electronic prescriber and be eligible to receive a 2011 eRx incentive payment, an eligible professional must use a qualified system to generate and report one or more electronic prescriptions associated with a patient visit - for a minimum of 25 unique visits per year for individual eligible professionals and between 75-2,500 unique visits for selected Group Practice Reporting Option I or II (GPRO I or II) participants. Each visit must be accompanied by the electronic prescribing G-code (G8553) attesting that during the patient visit at least one prescription (new or refill) was electronically generated.

Reference: <http://www.cms.gov/ERxIncentive>

Question #10629: Will interim feedback reports be available for the 2011 eRx Incentive Program?

Answer: Yes, but the focus will be on the eRx payment adjustment for this interim feedback report. The report will contain information regarding payment adjustment reporting criteria and assessment status for eligible professionals and selected group practices (GPROs). Each report will provide information on the number of qualifying eRx instances (numerator counts) and applicable cases that could be reported (denominator), but will not indicate a participant's incentive eligibility.

CMS will issue interim eRx feedback reports to all eligible professionals who submitted at least one denominator-eligible claim during the eRx payment adjustment reporting period of January 1 through June 30, 2011, as well as for GPROs who self-nominated to report the eRx measure as a group. It is anticipated that the reports will be available in the November/December 2011 timeframe.

Eligible professionals can request individual National Provider Identifier (NPI)-level reports through their Carrier/Medicare Administrative Contractor (MAC). Taxpayer Identification Number (TIN)-level and GPRO reports will be available on the Physician and Other Health Care Professionals Quality Reporting Portal (Portal) at <http://www.qualitynet.org/pqri> and will require an Individuals Authorized Access to CMS Computer Services (IACS) account. Reference: <http://www.cms.gov/ERxIncentive>

Question #10631: How long do eligible professionals have to actually submit claims for ensuring the data is processed into the NCH file for analysis?

Answer: For 2012 eRx Payment Adjustment analysis, the 10 required G8553 events MUST be reported via the claims reporting option, NOT via a CMS-qualified registry or qualified EHR. The six-month claims reporting period ends after June 30, 2011. As CMS is allowing just one month to receive submitted claims into the NCH file, the deadline is July 31, 2011.

Please be aware that Medicare Part B Carriers/Medicare Administrative Contractors (MACs) only submit claims to the NCH every Friday, so the last Friday would be July 29, 2011. Participating eligible professionals are encouraged to ensure their claims have been submitted to Carriers/MACs by mid-July 2011 or earlier.

Please note: Normally a two-month time-frame after the close of the program year is allowed for completing all Physician Quality Reporting System and eRx Incentive Program claims submissions. However, for determining the 2012 eRx payment adjustment, the timeframe for receiving eRx claims is shortened to one month.

Reference: <http://www.cms.gov/ERxIncentive>

Question #10632: Can Durable Medical Equipment supplies that are electronically prescribed be counted toward the eRx Incentive Program, using the G8553 submission code, in order to earn the eRx Incentive, or to avoid the eRx Payment Adjustments?

Answer: Yes, any and all Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) that can be transmitted electronically can also be counted as "valid eRx events" for the eRx Incentive Program using the G8553 submission code, in order to earn the eRx Incentive, or to avoid the eRx Payment Adjustments. This would include, for instance, DME-prescribed walkers, wheelchairs, shoes/socks for diabetic patients, diabetic testing supplies, insulin pumps, leg braces, prosthetics, CPAP machines, etc. However, the DMEPOS charges may not be included in your Total Allowed Charges calculation for the eRx Incentive Program, as most DMEPOS supplies would normally be paid under the DME Fee Schedule. Only those Medicare Part B allowed charges paid based on the Physician Fee Schedule (PFS) are included in the incentive payment calculation.

Additionally, in order to count DMEPOS electronic prescriptions towards the eRx Incentive Program, providers would need to meet the normal eRx requirements, such as using a qualified eRx system and electronically prescribing during an eligible visit as defined in the denominator of the eRx measure. Please see the 2011 eRx Measure Specification for more details at http://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp. Reference: <http://www.cms.gov/ERxIncentive>

Question #10636: If an eligible professional electronically prescribes over-the-counter (OTC) medicine, will this be counted for purposes of the Electronic Prescribing (eRx) Incentive Program?

Answer: If an eligible professional sends an eRx (via a qualified eRx system) to the pharmacy electronically (for a denominator-eligible visit) then the eRx event would count—even for an OTC medicine. The key is the prescription needs to be sent electronically to a receiving entity and the system needs to be able to check for the dose, and drug-drug interactions, etc., if they are available, just like for a regular eRx.

Question #10643: If an eligible professional participating in the Electronic Prescribing (eRx) Incentive Program completes an electronic prescription later in the day (or on the next day) for a denominator-eligible encounter, can (s)he report on the eRx mea

Answer: Yes, the eligible professional may report G8553 if the eRx is associated with a qualifying office visit. At least one prescription, created during the encounter, must be generated and transmitted electronically using a qualified eRx system. The eligible professional does not have to be the one to enter the eRx into the system; a staff member may do so on his/her behalf. The electronic prescription may be completed during the visit, later in the day, or even on the following day. Eligible professionals should follow the usual claims-based reporting or registry-based submission principles.

See the 2011 eRx Measure Specification for additional information (<http://www.cms.gov/ERxIncentive> > E-Prescribing Measure > Downloads).

Question #10644: Can an eligible professional participating in the Electronic Prescribing (eRx) Incentive Program report on the eRx measure if (s)he electronically prescribes a medication for a patient but the intermediary (i.e., SureScripts) converts it to a fax?

Answer: It is acceptable for the eligible professional to report G8553 (at least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system) if the eRx is created and transmitted electronically using a qualified system from the provider's office to the pharmacy. If the intermediary converts an electronic prescription to a fax after the prescription leaves the doctor's office (i.e., the receiving pharmacy cannot receive an electronic prescription), the eligible professional can report G8553, that an electronic prescribing event took place, and this would count toward the eRx requirements (assuming it is submitted with a denominator-eligible visit).

There is no requirement to electronically prescribe through a network like SureScripts; the eRx can be transmitted directly to a pharmacy. The requirement is for the prescription to leave the eligible professional's office as an electronic prescription and not a fax.

See the 2011 eRx Measure Specification for additional information (<http://www.cms.gov/ERxIncentive> > E-Prescribing Measure > Downloads). According to the measure specification, eRx is the transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, including an eRx network. Electronic prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. (Faxes do not qualify as electronic prescribing).

Question #10645: Are exclusion modifiers (1P, 2P, 3P) and the 8P reporting modifier allowed or considered in the Electronic Prescribing (eRx) Incentive Program?

Answer: Exclusion or reporting modifiers are not included in the 2011 eRx measure; therefore, modifiers reported for the measure will not be considered for measure analysis. Eligible professionals are encouraged to thoroughly review the current program materials and measure specifications and follow the respective reporting instructions for the measure. Reference: <http://www.cms.gov/ERxIncentive>

Question #10646: If a physician or other eligible professional who is participating in the eRx Incentive Program needs or chooses to have another professional fill in as a Locum Tenens, will the services furnished by the Locum Tenens be included in the analysis of the eRx participant's reporting rate?

Answer: Only if the Locum Tenens is reporting using the original eligible professional's Taxpayer Identification Number/National Provider Identifier (TIN/NPI) combination will the services be included in reporting rate analysis. If the Locum Tenens is using his or her own NPI, it would be a different TIN/NPI from the doctor for whom they are covering, and thus, would not count toward the original doctor's eRx numbers. Reference: <http://www.cms.gov/ERxIncentive>

Question #10661: What is meant by "unique" patients or events in the Physician Quality Reporting System or eRx Incentive Program?

Answer: The term "unique" is used differently in Physician Quality Reporting than in the eRx Incentive Program. For eligible professionals participating in Physician Quality Reporting, unique is used in the context of claims-based reporting or registry-based submission of 30 different patients or procedures for a Measures Group 30-patient sample option.

For example, the same patient undergoing a procedure on two different days could each count for the perioperative Measures Group.

For selected Group Practice Reporting Option II (GPRO II) participants, unique is also in the context of claims-based reporting or registry-based reporting of patients in a measures group. The required number of patients varies based on tier assignment. If an eligible professional is part of a group but is reporting individually, events or visits during the reporting period (January 1 through December 31, 2011) will be considered a successful electronic prescriber. He or she

should include G8553 (at least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system) on denominator-eligible instances. As this is unique events instead of patients, the eligible professional could include some of the same patient(s) in the 25 events, if the same patient(s) returned for an office visit on a different date of service. Each of the 25 instances should be associated with only one visit/encounter.

If three different medications are prescribed for one patient during one visit/encounter and then transmitted electronically, that would be considered one unique event. See the 2011 Electronic Prescribing Incentive Program Measure Specification (<http://www.cms.gov/ERxIncentive> > E-Prescribing Measure > Downloads)

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Question #10662: What is meant by the 10% threshold check for the 2011 Electronic Prescribing (eRx) Incentive Program?

Answer: An additional requirement for eRx incentive eligibility is that at least 10% of an eligible professional's Medicare Part B allowable charges must originate/be comprised of codes from the CPT/G-codes in the measure's denominator. CMS will add all of an eligible professional's Part B allowable charges for services that appear in the denominator of the measure and divide this sum by his/her entire Medicare Part B book of business for the year. If this fraction is less than 10%, the eligible professional will not receive the 1% incentive even if the required number of prescriptions were sent electronically.

Please note that an eligible professional cannot earn an incentive in both the Electronic Prescribing Incentive Program and the Medicare EHR Incentive Program, as these two programs are mutually exclusive. An eligible professional can, however, be subject to a payment adjustment in 2012 for not reporting at least 10 eRx events via claims in the first six months of 2011. To avoid the 2012 eRx Payment Adjustment, an eligible professional must report (via claims) that at least one prescription for Medicare Part B FFS patients created during an encounter that is represented by one of the codes in the denominator of the 2011 eRx measure was generated and transmitted electronically using a qualified eRx system at least 10 times during the 2012 eRx Payment Adjustment reporting period (that is, January 1, 2011 through June 30, 2011).

An eligible professional is excluded from the payment adjustment if any of the following apply:

- The eligible professional does not clear the 10% threshold in the first six months of the 2011 eRx reporting period (January 1-June 30, 2011);
- The eligible professional has fewer than 100 encounters defined by the eRx denominator codes with Medicare Part B patients in the first six months of 2011;
- The eligible professional does not have prescribing privileges; -
- The eligible professional practices in a rural area without sufficient high-speed Internet access; or
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing.

The last two are considered hardship exemptions and will require the provider to submit a new G-code on an eligible claim during the first six months of the year attesting to the hardship. If you are an MD, DO, PA, or NP and you do not electronically prescribe at least 10 times in the first six months of 2011, you may see your Medicare Physician Fee Schedule drop in 2012 to 99% of the 2012 PFS. Reference: <http://www.cms.gov/ERxIncentive>